**Department of Economic Security/Division of Developmental Disabilities**
**Request for Qualified Vendor Application/Response to Comments Received During 30 Day Public Comment Period**
**October 4, 2010**

The Division of Development Disabilities has developed a new Request for Qualified Vendor Agreement (RFQVA) posting on October 4, 2010 to replace the agreements that expire on December 31, 2010. The public comment period for the draft RFQVA began on Friday, July 16, 2010 and comments were accepted through August 20, 2010.

All comments and suggestions were reviewed and, when the Division was able to do so, the RFQVA was changed. In total, 27 agencies or individuals submitted comments, along with two provider organizations, and one sister agency. In total, 256 comments or questions were received and reviewed.

The following is a compilation of comments received and the Division's responses. If you have questions regarding a particular response, feel free to contact the Division at the following mailbox: DDDHotline@azdes.gov

During the RFQVA revision process, the Division recognized that several new mandatory requirements were being added to the Qualified Vendor applicant. The Division had no control over the majority of these new requirements, such as the IOG verification, e-verify, Central Registry Background check, direct care worker training, business continuity and pandemic response planning. While these new requirements are all necessary and important, they do have a direct impact on the Qualified Vendor's daily operations. As a result, the Division attempted to identify specific requirements that could be streamlined.

As the Division evaluated the comments and questions about specific provisions in the RFQVA, if it was determined that a provision was not required by Medicaid, AHCCCS, or other state or federal laws, statutes or rules, then consideration was given to the requested change and the potential impact.

Specifically, the Division reviewed internal reporting requirements with the intent to reduce the overall number. As a result, the Attendant Care monthly progress report has been eliminated. In addition, most services required monthly progress reports for each individual consumer. Twelve of these monthly service progress reports were changed to quarterly progress reports. For each service, for each consumer, there are now 8 less reports per year.

The Division values our partnership with the Qualified Vendors and will continue to explore additional ways to streamline processes.

**Section 3 Instructions**
**3.2.2 Consultants**

**Comment:**
*This section states that applicants shall not be represented by a consultant, and that all discussions and agreements be made directly with the applicant.*
*Why is this requirement in place?*

**Division Response:**
The intent of this requirement is to ensure accurate communication between the applicant and/or qualified vendor and the State. Specifically, during the application process, the Division needs assurances that the applicant understands the expectations of the qualified vendor agreement, as well as the specific business and programmatic requirements necessary to operate the program and service delivery system being proposed. While a consultant can be helpful in preparing documents and advising on policy direction, it is the applicant/qualified vendor that is ultimately responsible for business and program implementation and operations.

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**Section 3 Instructions**
**3.2.6 Application Updates and Amendments**

**Comment:**
*Does DDD expect applicants to revise their responses to each question in the QVA as part of this response, or can the previous responses for each service, as well as the general information, be saved?*
*Does DDD expect providers to complete every question within the individual services even though we address those issues, i.e.: IR process, grievance procedure, investigation process, etc. in general terms?*

**Division Response:**

New Applicants
All parts of the application must be completed. Please refer to the QVADS User Manual for New Applicants that is posted at: http://www.azdes.gov/ddd.

Current Qualified Vendors
In order to reduce the administrative burden for current qualified vendors, the application process has been modified. For instructions, current qualified vendors should refer to the QVADS User Manual for Existing Qualified Vendors that is posted at: http://www.azdes.gov/ddd/. Specifically, current contract information as of September 30, 2010 will be available, can be viewed, saved if changes are required and then submitted. To the extent that current qualified vendors have maintained information contained in the general information section and service questions of the Qualified Vendor system, this information can be simply resubmitted. If the current qualified vendor desires to make changes, then changes can be completed, saved and then

submitted. New hardcopy documents and information will need to be submitted such as Assurances.

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**Section 3 Instructions**
**Section 3.5 Verification**

**Comment:**
*What types of verification does DDD plan to perform?*

**Division Response:**
During the evaluation process of an applicant, the Division will use sources such as the Division Risk Incident Management System (RIMS), the Arizona Corporation Commission website, ACCURINT or Lexis/Nexis licenses for background checks, the Centers for Medicare and Medicaid public databases, and any available public or departmental data to verify information on an application, applicant and key staff.

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**Section 3 Instructions**
**Section 3.7.1 Evaluation Factors**

**Comment:**
*What is the DDD's network development plan? Can this be shared?*
*What will DDD do if an existing provider does not meet the development plan – will the provider be denied an agreement?*

**Division Response:**
As required by AHCCCS contract, the Division develops an annual network plan after reviewing potential growth, areas with unmet service needs and other issues identified by the Districts through the past year. The Division develops strategies which are then evaluated each quarter for progress and adjustments are initiated. At the end of each fiscal year, the Division evaluates the chosen strategies and develops a summary report which is included with the network plan for the subsequent year.

Since current vendors are already part of the Division's service delivery network it is not anticipated that any current vendors would be denied a contract agreement based on this requirement. The requirement is stated in A.A.C. R6-6-2104, B.3.

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**Section 3 Instructions**
**Section 3.7.2 Evaluation Process**

**Comment:**
*What if, after 90 days, DDD determines the applicant (a current provider) does not meet the criteria to have a contract? Will the applicant be allowed to resubmit the necessary documents to maintain their contract? Will client continuity be prioritized?*

*What happens if the criteria have not been met by 1/1/11, but the applicant is striving to do so? Can DDD be more specific here as to the timeframe that the QV has to provide the missing information?*

**Division Response:**
The Division's first priority is for consumer health, safety, quality of life and continuity of care. As the current Qualified Vendor Agreement (QVA) expires on December 31, 2010, new agreements/contracts must be in place by January 1, 2011 to continue service delivery without interruption. The Division anticipates needing additional information during the application process from current vendors and new applicants. As questions arise, the Division will contact the applicant and work through issues, obtaining updated information as needed. The Division tracks the status of qualified vendor applications, which allows it to respond quickly to vendor issues and make necessary adjustments. The Division will work closely with current vendors experiencing problems meeting the contractual requirements. In the event that we are unable to work through any outstanding issues in a timely manner, the Division will be prepared to transition individuals to other providers and settings. Current vendors are encouraged to submit their new applications as soon as possible to better ensure contract continuity.

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**Section 4 - Background**
**Division Credo, Vision and Values**

**Comment:**
1. *Do all individuals & families really have equal access to services and supports, in some instances there are extreme differences from one case manager to the next?*
2. *With the all time shortage of DDD support coordination staff; the partnerships & ongoing communication between them and the individuals, family members, & QV's has significantly changed.*
3. *Please elaborate on this concept, it is not always possible for the conditions to change especially if they are environmental or pertain to more than the one individual at a time.*
4. *How/where do "natural supports" fit into this criteria?*

**Division Response:**
The Division oversees and supervises support coordination to provide services as consistently as possible. In terms of the Division's Credo, Vision and Values, each consumer is approached as a unique individual and thus others may see this as inconsistent when in fact the system is intended to individualize approaches. Where there are "outliers" from the typical supports (either above or below), the Division works to identify the reasons and address those situations where circumstances do not support the level of service.

The Division's Credo, Vision and Values were developed with input from multiple stakeholders involved with supporting individuals with developmental disabilities. The

statements provide a foundation for service development and helps define the Division's direction.

1. Because the Division values equal access to services, there is a process in place for individuals and families to express dissatisfaction. When a support coordinator is a barrier to service access, the individual/family is encouraged to contact the District Program Manager.
2. This value statement is supported by the Division's commitment to the individual planning process in which (Arizona Long Term Care System) ALTCS members have face to face contact with a support coordinator and planning team every 90 days (or six months for group homes).
3. As a foundation for service development, this value statement challenges the agency to increase capacity at all levels of the service system to work on changing conditions that adversely affect people with developmental disabilities.
4. One could construe "natural supports" as fitting into each of the criteria cited, except "Responsive".

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**Section 5 Service Requirements**
**Section 5.1 Provider Qualifications No. 9**
**Communicate in Client's Language**

**Comment:**
*No. 9, which requires the vendor to be able to communicate in the client's language, is too broad and inclusive. Without compensation, it is not reasonable to believe that a provider can offer services in all possible languages.*

*This requirement to communicate in other languages is too broad and all inclusive. It is impossible to have staff fluent in all the thousands of languages spoken.*

**Division Response:**
It has been a long standing requirement of the Department to require in its contracts that services provided are culturally relevant and linguistically appropriate to the population to be served. The intent of this requirement is not that a vendor must offer services in all possible languages. However, at a minimum, vendors should establish an effective communication strategy when considering acceptance of a referral.

All Department contracts, including the QVA, must comply with all applicable requirements of state and federal law. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d et seq., prohibits discrimination based on national origin by government agencies that receive federal funding. Taking reasonable steps to ensure meaningful access to Medicaid services for persons with limited English proficiency is one way the Department ensures compliance with Title VI. This requirement applies to all programs and activities administered by DES, including contractors who provide direct services funded by Medicaid to DES/DDD consumers.

In addition, these requirements are also based on federal regulations for Medicaid managed care plans (42 C.F.R. 438.10(c) that requires MCO, PIHP, PAHP and PCCM providers to make their written information available in the prevalent non-English languages in its particular service area; and to make oral interpretation services available at no charge for all non-English languages, not just those identified as "prevalent."

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**Section 5 Service Requirements**
**Section 5.1 Provider Qualifications No. 11**
**Central Registry**

The Division received comments from six providers and one provider organization regarding the requirements in Section 5.1 Provider Qualifications No. 11 pertaining to Central Registry and Background Check. These comments ranged from not understanding the requirement (A.R.S. § 8-804) referenced in the RFQVA to specific process questions.

**Clarification of Requirement:**
This is required by A.R.S. 8-804 (as may be amended) which requires the names of all direct care staff to be submitted to the Central Registry and Background Check. The form for submitting the request is Attachment 9.G. to this RFQVA. This form is a template for the required data elements. Provided that the vendor furnishes all data elements, any format is acceptable. In addition to hard copy information, vendors may submit employee information electronically. Specific instructions for this process are posted with the final solicitation.

**Comment:**
One vendor, while understanding the need to thoroughly screen employees, articulated the operational concern of not being able to hire staff until central registry and background checks were completed. The proposed suggestion was to model the central registry check after the current fingerprinting requirements as stated in Sections 6.5.4.1.1 through 6.5.4.1.3. This would allow vendors to hire new staff and for those staff to begin work under direct supervision of an employee who has received clearance from the Central Registry. Similar to the fingerprint clearance card process, if a vendor staff person does not "clear" the central registry and background check, employment would be terminated at that time.

**Division Response:**
This requirement goes into effect for providers on January 1, 2011. Qualified Vendors currently serving consumers will want to submit applications, including a listing of direct service staff, as soon as possible to receive clearance prior to contract award.

New applicants will be able to submit direct care staff names for Central Registry checks prior to accepting consumers into their programs.

At this time, there is no provision within the Department that would permit an individual who is waiting for clearance from the Central Registry to work under the direct supervision of an employee who has already received Central Registry Clearance. The Division appreciates the suggestion and continues to explore this option within the Department. We expect to have resolution regarding this suggestion prior to January 1, 2011. In the meantime, please submit your names to the registry as soon as possible so that your employees will have completed this process before January 1, 2011.

**Comment:**
*Will there be an affidavit process that allows the above process?*

**Division Response:**
There is no affidavit option for the central registry process at this time.

**Comment:**
*Is this a one time only provision? Is this done one time only with the submittal of the vendor application? Does every employee need to be included?*

**Division Response:**
It is a one time provision for each employee working with the same vendor with no breaks in employment.

It is an ongoing requirement for the vendor since the vendor is responsible for submitting newly hired staff for central registry before the staff can work with Division consumers.

**Comment:**
*Will this be an ongoing process (will employees have to be checked every year?)*

**Division Response:**
This is an ongoing process for all new hires. However, once an employee has been checked and remains with the same vendor without a break in employment, there is no requirement to be re-checked every year.

**Comment:**
*What are the requirements for current employees?*

**Division Response:**
Current employees should be submitted for central registry checks during the application process as soon as possible.

**Comment:**
*What is the turnaround time for checks?*

**Division Response:**
The expectation is that central registry and background checks will be completed within 30 days.

**Comment:**
*Who completes the form (employee or employer)?*

**Division Response:**
The vendor (employer) prepares the form and submits it to:

Arizona Department of Economic Security
Division of Children Youth and Families – Contracts Unit
Attn: CPS Background Check
1789 West Jefferson Street, Site Code 940A
Phoenix, Arizona 85007

Please ensure that the submitted forms contain the following:

DD Qualified Vendor Application
RFQVA #710000

Vendors may also choose to add their own internal tracking number.

**Comment:**
*Is the check "portable"? If an employee has cleared this check with one employer, is there proof he or she can take to their next employer?*

**Division Response:**
No, this check is not "portable. "

**Comment:**
*What are principles (Section 6.5.3.1.6)?*

**Division Response:**
"Principals" are the person(s) in a business who direct the work of employees. This section was revised to clarify that only persons who provide direct services to children or vulnerable adults are required to submit to the central registry.

**Comment:**
*How much will it cost? What kinds of fees are involved?*

**Division Response:**
There are no fees or payments required from the vendor for processing central registry and background checks, although some other states do charge for this service.

**Comment:**
*How soon can providers start to submit employees?*

**Division Response:**
Providers can start submitting their current employees for central registry checks as soon as the vendor submits the QVA application. It is advisable to submit the application as soon as possible.

**Comment:**
*What is the appeal process?*

**Division Response:**
The appeal process is available to the person against whom a report of abuse or neglect has been substantiated. Information about the appeal process is available at the ACYF website.

**Comment:**
*When will there be a similar process for adults?*

**Division Response:**
The requirement for CPS Central Registry check applies to direct care workers providing services to vulnerable adults as well as children. While there is no statutory requirement to check the Adult Protective Services registry, the APS registry is public information available to the Division (and Qualified Vendor, upon request).

**Comment:**
*Is this the fingerprint card? Isn't this redundant reporting of all employees who are already fingerprinted?*

**Division Response:**
No, this is not a fingerprint clearance card. The Central Registry Background Check is a separate requirement in A.R.S. 8-804 (as may be amended).

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**Section 5 Service Requirements**
**Section 5.1 Provider Qualifications No. 12**

**Comment:**
*I would suggest that the Qualified Vendor be allowed to have three verifiable references on file for each direct care staff which may include letters.*

**Division Response:**
This requirement is a provision of A.A.C. R6-6-1504.3.a, which states:

> "3. From sources other than the applicant, the documents listed on the application form as follows:
>
> a. Three letters of reference as prescribed in R6-6-1504(D), . . . "

This requirement is enforced by the Office of Licensing, Certification, and Regulation (OLCR).

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**Section 5 Service Requirements**
**Section 5.2 Staffing No. 3**

**Comment:**
*No.3. The word "all" in this statement is concerning. Can the statement include the specific training required (by reference to A.A.C.)?*

**Division Response:**
This section was changed to read as follows: The Qualified Vendor shall ensure that no direct service staff work unsupervised with consumers until all required training set forth in A.A.C. R6-6-1520 (as amended) has been completed.

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**Section 5 Service Requirements**
**Section 5.2 Staffing No. 5**

**Comment:**
*Does No. 5 apply to all vendors?*
*It is appropriate to assume that a provider will have staff trained for a particular consumer they have agreed to serve, but not trained to handle any possible need of any consumer.*

**Division Response:**
Section 5 sets forth the general requirements that the Qualified Vendor will be expected to comply with regarding the delivery of agreement services. This specific requirement is the expectation that the Qualified Vendor will have a range of trained staff available to effectively meet the variety of needs including those with intensive behavioral, physical, and medical challenges. This means that any support need identified by the team for a specific consumer should be part of the orientation for the agency staff when learning to support that consumer.

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**Section 5 Service Requirements**
**Section 5.2 Staffing No. 7**

**Comment:**
*I would suggest that this item be removed as ensuring fitness seems to have medical overtones which may be impossible for a provider to take action on independently even if they believed that the evaluation indicated such. This very quickly could enter the employment law of reasonable accommodations.*

*Assessing the effectiveness of the relationship between the staff and consumer and consumer's representative is already accomplished through performance evaluations.*

**Division Response:**
The Division requires as fundamental to Quality Assurance that qualified vendors ensure the continuing ability and quality of direct care staff to provide services.

**The Division changed the language to the following:**
The Qualified Vendor shall routinely monitor and supervise the direct service staff to ensure the direct service staff has the skills and abilities to work with the consumers and has developed a positive relationship with the consumers and their families or representatives.

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**Section 5 Service Requirements**
**Section 5.3 Training No. 1 (1.3)**

**Comment:**
*Is the specialized training considered to be CPR, First Aid, and Article 9?*
*Please specify ALL "specialized Training" requirements especially if there have been changes made.*

**Division Response:**
CPR, First Aid and Article 9 are separate explicit requirements listed in A.A.C. 6-6-1520. Specialized training refers to additional "specialized" training, for example, CIT which may be required depending on the needs of the individual being served. The new AHCCCS required training for direct care workers providing attendant care, housekeeping and respite (when attendant care tasks are provided) is another example of specialized training.

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**Section 5 Service Requirements**
**Section 5.3 Training No. 3**

**Comment:**
*No. 3 requires the provider to encourage participation in training by consumers and parents. Although this sounds like a good idea, it is impractical. Providers need to have quality control over the training given to staff. In addition, providers have enough difficulty coordinating the scheduling for training, without having to take other people's schedules into account. Providers are also concerned that there are a number of sensitive issues that are raised in training that might be uncomfortable for consumers. Inclusion of consumers and parents should be optional.*

*As idealistically wonderful sounding as this may be, it is impractical. We need to have quality control over the training given to staff and have enough difficulty in scheduling time to provide all required training without trying to fit in individuals from outside the organization. Including participants creates a different issue. Many of the topics that must be covered in our staff training are sensitive issues for participants and could cause them distress if included in the training.*

**Division Response:**
Consumer participation has been a specific part of the applicant's Quality Management Plan for the Qualified Vendor Agreement since 2003. Eliminating this requirement is contrary to the Division's values as stated in § 4 Background. In the current electronic application, there is an area titled Consumer Involvement for the applicant to "Describe all of the other methods used by your organization to provide opportunities for consumers/families/consumer representatives to be actively involved in your organization's operations (i.e. advisory groups, staff recruitment, staff training and development, monitoring, social events, etc.) Please limit your response to one-half page."

Qualified Vendors are not expected to change schedules to accommodate this requirement. The Division's expectation is to encourage having consumers and families present as part of the training. Where practicable, it is desirable to involve consumers in training. If a training curriculum and calendar are available, there are many ways to provide opportunities for consumer and family participation.

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**Section 5 Service Requirements**
**Section 5.3.1 Direct Service Training Requirements**

The Division received comments from five providers and one provider organization regarding the requirements in Section 5.3.1 Direct Services Training Requirements. The majority of comments and questions center on the new mandatory AHCCCS training for direct care workers (DCW) in attendant care, housekeeping and respite (when attendant care tasks are provided).

**Comment – General:**
*The new AHCCCS required training for direct care workers in attendant care, respite and housekeeping seems onerous, and will be especially difficult for small agencies. The cost is significant, due to training of staff, as well as workers, and revision of all current training materials. Providers remain very concerned about the* ***portability*** *of the training. Workers will attend training with one provider and then become an employee of another firm, resulting in no reimbursement to the training provider agency.* ***Liability*** *concerns have also arisen. If an employee is trained at one agency, then becomes an employee of another agency and causes an issue, can the second provider agency or the plaintiff sue the first over quality of the training?*

**Division Response:**
In March 2004, former Governor Napolitano issued an Executive Order for state agencies to plan for "Aging 2020". She created the Citizens Work Group on the Long-Term Care Workforce to study issues surrounding Arizona's direct care workforce. In April 2005, the recommendations of this workgroup were published in the report, *"Will Anyone Care? Leading the Paradigm Shift in Developing Arizona's Direct Care Workforce".* The report contained 10 recommendations. One recommendation addressed the state's

responsibility for regulating oversight of direct care workers and developing a standardized, uniform and universal training curriculum.

AHCCCS has been identified as the lead state agency implementing standardized Direct Care Training Guidelines and Competency Testing. Initial roll out begins January 1, 2011; with full implementation targeted for January 30, 2012. AHCCCS has incorporated this in contract for ALTCS program contractors, including the Department. As such, the Department must include the new requirement in policy and contracts starting January 1, 2011. Additional information regarding the Direct Care Workforce Initiative is available at http://www.azdirectcare.org.

***Division Response - Portability of Direct Care Worker Training:***
Under the current training model, each Qualified Vendor is responsible to assure that Direct Care Workers are trained. The current Qualified Vendor Agreement requires that new Direct Care Workers receive initial training to perform their job responsibilities when hired regardless of whether or not they were trained by a prior Qualified Vendor.

Under the new mandatory AHCCCS training model for those services specified, when a Direct Care Worker with a training certificate is employed by another Qualified Vendor, the Qualified Vendor can choose to fully train the worker in their own AHCCCS approved curricula, modify the training based on the new staff's knowledge, or forgo all training. However, Qualified Vendors need to assure the competency of their employees, regardless of prior training and testing.

***Division Response - Liability Concerns:***
The new Direct Care Worker requirements do not prevent a Qualified Vendor from deciding to re-train and re-test new employees who have previously met the Direct Care Worker training and testing requirements; provided that the Qualified Vendor's curricula is approved by AHCCCS. A Qualified Vendor will need to determine if they want a certified Direct Care Worker to repeat the training and testing requirements.

**Comment:** *Two vendor agencies expressed concerns that because of the overall ambiguity of the language in this specification, the Division could apply the direct care worker training/curriculum beyond the scope of the AHCCCS intent. In addition, it was noted that every specification contains the same language and does not specify the limiting of the application of these additional AHCCCS training requirements only to the AHCCCS specified services.*

**Division Response:**
Upon review, the Division recognizes the confusion related to the training specifications for Direct Case Workers. The Division's intent is to apply the mandatory AHCCCS requirement only to those services that AHCCCS requires (i.e. attendant care, housekeeping and respite (when attendant care tasks are provided). It is not the Division's intent to modify the AHCCCS requirement to include additional services.

The Division has reviewed and modified, where appropriate, Sections 5.3, 5.3.1 and the training requirements throughout the RFQVA to be consistent with AHCCCS mandates and training requirements of the Division.

**Comment:**
*The Division received a number of comments regarding the requirement for submitting curriculum for direct care professionals and in-home direct care workers. Specific comments were concerned with the additional time and costs to submit summaries, outlines and schedules. Several vendors suggested that a complete copy of training materials should be available for review upon request.*

**Division Response:**
The Division concurs with the suggestion that a complete copy of training materials should be available for review upon request by the Division and has incorporated this change in the RFQVA.

However, there are specific AHCCCS curriculum requirements, separate and apart from the Division, for the Qualified Vendor to become an approved Direct Care Worker Training and Testing site. These AHCCCS requirements are posted on the Direct Care Worker website: http://www.azdirectcare.org.

**Comment:**
*What services does this apply to?*

**Division Response:**
The mandatory AHCCCS training requirements for Direct Care Workers applies to attendant care, housekeeping and respite (when attendant care is provided) services in accordance with the AHCCCS Medical Policy Manual (AMPM) Chapter 1200 and the AHCCCS Contractor's Manual (ACOM).

**Comment:**
*Will the "Arizona Direct Care Curriculum Project-Principles of Caregiving" be required training of all direct service staff? If so, is it in addition to the other training provided by the QV?*

**Division Response:**
The mandatory AHCCCS training requirements for Direct Care Workers applies to attendant care, housekeeping and respite (when attendant care is provided) services in accordance with the AHCCCS Medical Policy Manual (AMPM) Chapter 1200 and the AHCCCS Contractor's Manual (ACOM). It is believed that most Qualified Vendor training curriculum will meet or exceed the standards set by the Arizona Direct Care Curriculum.

**Comment:** *What will occur when long-term employees do not pass the test?*

**Division Response:**
Staff employed with a qualified vendor prior to January 2011 will be grandfathered and not be required to take the training, unless the staff person moves to a different Qualified Vendor.

**Comment:**
*How are part time employees handled with respect to continuing education?*

**Division Response:**
Continuing education is the same regardless of the number of hours worked by a Direct Care Worker.

**Comment:**
*How does a qualified vendor become an approved "Testing and Training Site"?*

**Division Response:**
Qualified Vendors that employ direct care workers have the option of becoming an AHCCCS approved "training and testing site" or sub-contracting with an approved "training and testing site" to train its employees.

For Qualified Vendors that choose to become an AHCCCS training and testing site, two processes are available. The Qualified Vendor can either use the free curriculum available through AHCCCS or complete a process with AHCCCS that would approve the Qualified Vendor curriculum for the Direct Care Worker training.

Qualified Vendors may choose to use the AHCCCS free curriculum that is available with competencies and information geared toward passing the standardized test. AHCCCS believes that the availability of this free curriculum will make it easier for small agencies to participate in ALTCS and the requirements to provide well-trained Direct Care Workers.

For providers that prefer to use existing training materials, AHCCCS will implement a process to crosswalk the provider's existing training material with the Direct Care Worker standard competencies to ensure that provider's curricula comports with the standardized training. Once approved by AHCCCS, the Qualified Vendor's training material will be deemed to meet the Direct Care Worker training standards. This means that existing material only needs revision if it does not address all competencies.
Additional information for becoming an AHCCCS Direct Care Worker Training & Testing Site is available at http://www.azdirectcare.org.

**Comment:**
*Is it required that all QV's become an approved Testing and Training Site or is there an option to send prospective employees for training at another location?*

**Division Response:**
No, it is not required that all Qualified Vendors become an approved Testing and Training Site. There are options for employees to receive training from other sources.

**Comment:**
*Who will those Testing and Training Sites be and what will their schedules and rates be?*

**Division Response:**
Please refer to http://www.azdirectcare.org. Several Testing and Training Sites, including several community colleges, already have schedules available.

Please note that any Direct Care Worker Training and Testing Site that charges students to take the training must be licensed by the Arizona Board of Post Secondary Education. This is not an AHCCCS requirement but a requirement of the Arizona Board of Post Secondary Education.

**Comment:**
*Will the 6 hours of continuing education be offered by the Testing and Training Sites on evenings and weekends as needed?*

**Division Response:**
It depends on the Testing and Training Site.

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**Section 5 Service Requirements**
**Section 5.4.1**

**Comment:**
*I suggest that the last statement in this item be struck.*
*". . . If services are provided to a group by one provider, like a group home, the consumers shall collectively choose the Qualified Vendor."*

*Movement into and out of services which are established does not permit throwing out the entire group and establishing a new group is to have a collective decision process to occur. Sensitivity by the provider to accepting individuals in group settings which have a have a probability of doing well together is a better alternative.*

**Division Response:**
This provision is consistent with A.A.C. R6-6-2107, regarding consumer choice.

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**Section 5 Service Requirements**
**Section 5.5 Service (Prior) Authorization**

**Comment:**
*The last sentence of the first paragraph states "Authorization levels will be set by the Division to reflect the current needs of the consumer. Aren't the services needed determined by the ISP Team?*

**Division Response:**
Teams make recommendations. However, the Division has always maintained the final responsibility to ensure services are medically necessary and based on assessed need. The Division has outlined the service levels which require additional approval, beyond the Support Coordinator, before the service can be authorized. The Division also has the responsibility to determine if state only funds are available when the team identifies services which are not covered by the ALTCS program.

**Comment:** *The first sentence of the second paragraph states: "Prior authorization is required. . . "*

*Sometimes families have the DSP do overnight respite WITHOUT NOTIFYING THE QV, thereby exceeding the 13 hours and the QV has to request the auth after the fact. What happens in this instance?*

**Division Response:**
Respite authorizations are put into the system for the annual amount and adjusted when days rather than hours are requested. This adjustment would not impact the provider since the total hours of respite would not be altered.

**Comment:**
*The last sentence of the second paragraph states "Qualified vendors can expect reasonable notice of changes in authorizations for future service delivery."*

*The term "reasonable" needs to be defined. Providers already have difficulty in obtaining ISPs from support coordinators.*

**Division Response:**
The team meets as a group and most changes made in these meetings are known by all the participants. If a team recommends a service that requires prior authorization beyond the Support Coordinator, the provider would know to not implement that level of service until prior authorization is received. If a current level of service is being reduced, the Division must follow due process timelines before the service can be reduced. This is another means to provide reasonable notice to the provider. While providers do not receive a copy of the Notice of Action, their participation in the ISP team process and/or the FOCUS authorization process would inform them when the Division has denied a service.

**Comment:**
*The last sentence of the third paragraph states "prior authorization is necessary for prior to service delivery, but future service delivery is not guaranteed by the payment authorization."*
*What does this mean?*

**Division Response:**
This is simply stating that a provider cannot assume that an initial level of service authorized at the beginning of an ISP year obligates the State to provide that level of service for a full 12 months. The team meets each quarter to review and potentially adjust services.

**Comment:**
*Can DDD change or cancel the authorization at any time (i.e. outside of the ISP process)?*

**Division Response:**
The ISP is not a contract. Services may be reviewed at any time. In addition, under certain circumstances such as legislative action, the Division may be required to change service authorizations.

**Comment:**
*Authorizations for respite may not be input until afterwards because it is unknown whether the service will be counted as hourly or daily respite.*

**Division Response:**
Respite authorizations are entered into the system for the annual amount and adjusted when days are requested, rather than hours. This adjustment would not impact the provider since the total hours of respite are not altered.

**Comment:**
*Support Coordinators are telling providers to perform services without an authorization, especially for bridge auths. Support coordinators are frequently not getting auths in the system on a timely basis. What should the provider do in these circumstances?*

**Division Response:**
There are some circumstances in which a provider may need to communicate with the appropriate District if a Support Coordinator has not entered an approved service into FOCUS.

**Comment:**
*The third sentence of the fourth paragraph states that "while the support coordinator will attempt to provide reasonable notice to the Qualified Vendor when an ISP authorization changes, the Qualified Vendor is responsible to verify that the service is authorized prior to providing the service."*

*This statement is problematic in several ways. Support coordinators have very large caseloads now, and providers are wary of the definition of "attempt"; the word "reasonable" is still an issue (see no. 2 above); and the idea that the qualified vendor can check every consumer for every service before delivering the service is unrealistic. Not only is this last item very time-consuming, but there is already a substantial problem with ISP changes being put in the system on a timely basis. In addition, there is a problem with ISP authorizations being entered on a retroactive basis; in this case, the providers wouldn't get paid even though they did check the authorization.*

**Division Response:**
The provider has a responsibility to ensure the service is authorized before providing the service. When a provider has demonstrated due diligence in communicating with the District and has received, at a minimum, written confirmation of the authorization, the Division has paid the claim.

The Division reviews payment denials each month as claims are submitted by providers. During the month of May 2010, only about 1% of the total 707,846 claim lines submitted were denied because of prior authorization problems.

**Comment:**
*Two vendors expressed concern on the absence of contractual language regarding the approval process for direct service hours approved for group homes. This process is not the responsibility of the support coordinator or part of the ISP process.*

*One provider suggested that the contract be enhanced to further specify the Division's use of the Habilitation Group Home Matrix.*

**Division Response:**
The direct service hours required for each group home are dependent on the individuals living in the home and their specific needs. Because the individuals have different Support Coordinators, district resource staff working in conjunction with the group home Qualified Vendor determine the appropriate direct staffing hours for each home. These direct care staffing hours are documented on the Habilitation Group Home Matrix. The Division concurs with this request and has added language in Section 7, Service Specifications for Habilitation, Group Home to address the group home direct service hours approval process (Habilitation Group Home Matrix).

---

**Section 5 Service Requirements**
**Section 5.6 Referrals for Services**

**Comment:**
*Does this section require a qualified vendor to respond to every vendor call? If not, can that be clarified? Is there a definition of "vendor call"?*

*I would suggest that the response to vendor call referrals be continued as it currently exists and requests that those vendors who are interested and have the capacity respond.*

**Division Response:**
This section has been revised to clarify that a vendor has the option to respond to a specific vendor call and the responsibilities of a vendor for whom a referral for services has been made.

---

**Section 5 Service Requirements**
**Section 5.7**

**Comment:**
*One provider suggested that some additional language be added to this section (and Division policy) to indicate that the QV would have the responsibility of supporting all applicable ISP goals and ensure that all applicable objectives are implemented once they have agreed to the ISP. As the Division is aware, there are instances when a completed ISP packet may contain inaccurate information but the provider has not received a copy of the finalized ISP packet and therefore should not be held accountable under contract to a condition that may be inaccurately documented.*

**Division Response:**
The ISP is a planning document, not a contract. If the vendor receives an incomplete or inaccurate final ISP packet, the vendor should contact the support coordinator.

---

**Section 5 Service Requirements**
**Section 5.9**

**Comment:**
*Historically the Vendor who is discontinuing the role as service provider is not involved with participating in the development of an ISP with the new service provider. Information regarding service is shared through the Support Coordinator to the new provider. This requirement will represent a significant operational change if enacted.*

**Division Response:**
The role of the exiting vendor is to transition all necessary records and consumer property to the new vendor. The exiting vendor is also obligated to actively participate in a safe transition of responsibility to the new vendor.

---

**Section 5 Service Requirements**
**Section 5.10 Recordkeeping No. 2**

**Comment:**
*In No. 2, subsection 2.5, clarification is needed as to whether this pertains to the client's attendance or the direct service provider's attendance.*

**Division Response:**
This requirement refers to the consumer's attendance, and "Consumer" was added to the final document.

---

**Section 5 Service Requirements**
**Section 5.10 Recordkeeping No. 3**

**Comment:**
*No. 3, providers object to being required to produce client records at no cost. A nominal fee should be allowed for the manpower and supplies to process these requests.*

*One provider suggested including contractual language that protected the qualified vendor from excessive record request.*

*This states that "all records" created and maintained by the QV shall be made available to the consumer and his/her legal representative and that copies must be produced at no cost. It indicates the same requirement of the Division. The Division is encouraged to re-evaluate this requirement to specify that all records created and maintained (by either the QV or Division) that pertain to that consumer be made available to the consumer or his/her legal representative. Without this level of definition, the QV would be required by contract to provide copies of records to consumers and/or their legal representatives if the information requested related to other consumers, staff or financial records. This seems to be beyond the scope of the intent of this recordkeeping requirement.*

**Division Response:**
This is a requirement in the AHCCCS ALTCS contract with the Division, ALTCS DDD YH6-0014 (amended). "The member's medical record is the property of the provider who generates the record. Each member is entitled to one copy of his or her medical record free of charge."

The contract language has been changed to include a limitation to one free copy annually and contract language was added to clarify that all records that pertain to the consumer will be made available.

---

**Section 5 Service Requirements**
**Section 5.10 Recordkeeping No. 4**

**Comment:** *In No. 4, the words "all" and "reasonable" are concerning. These terms should be defined. There are records which are maintained by the vendor which are inappropriate to share with the Division, such as certain information in personnel files. Also, who determines what is "reasonable"?*

**Division Response**
Section 5.10 Recordkeeping No. 4 has been deleted from the RFQVA.

---

**Section 5 Service Requirements**
**Section 5.11**

**Comment:**
*Application and Use of Rate Book and Billing Manual - Are the current rates going to continue on through the January 2011 changes?*

*One provider expressed concern that all applicable rate basis/unit of service information has been removed from the service specifications. This information will apparently be referenced to only in the rate book and perhaps in the "Provider Manual". The removal of this critical information from the contract for exclusive inclusion in the Division publication (that may be revised at any time or without notice to the QV) is extremely disconcerting. As the Division and all QV's are aware, the inclusion of this information within the contract does provide the QV with some inherent financial safeguards, which are necessary in the development of operations, and in planning for the future. While it is certainly understood that the contract may always be revised and that services may only be funded to the level the state has appropriated, there is at least some contractual (thus financial) assurance to the QV that they rely upon the contract information (i.e., the current rate basis, definitions and assumptions, etc.) when planning for the organization. It is strongly encouraged that this information be reinstated within the contract in some manner.*

**Division Response:**
In order to streamline each service specification, billing instructions were eliminated because they are contained in the RateBook. The rate basis, definitions and assumptions that would be used for organizational planning purposes are the methodologies and assumptions used by the Division in compiling the benchmark rate schedule. The financial assurances are contained in A.R.S. 36-2959.

The current rates will continue through January 2011. As enacted by HB 2001 and reflected in the FY 2011 Appropriations Report dated May 24, 2010, for FY 2011, the Department of Economic Security shall not increase reimbursement rates for community service providers and independent service agreement providers contracting with the Division of Developmental Disabilities.

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**Section 6 Standard Terms & Conditions**
**Section 6.1.10 Definitions of Terms**

**Comment:**
*This definition seems to define Sunday as a normal business day.*

**Division Response:**
This was an error. The RFQVA language was changed to:

"Business Day" means between the hours of 8 AM and 5 PM Arizona time any day of the week other than Saturday, Sunday, legal holiday or a day on which the Division is authorized or obligated by law or executive order to close.

---

**Section 6 Standard Terms & Conditions**
**Section 6.1.20 Definitions of Terms**

**Comment:**
*This section has a very different definition of an independent provider than that which is provided in Section 3-4. Which is correct?*

**Division Response:**
This was an error. The RFQVA language was changed to:

"Independent Provider" as referenced in this document which means a person with no employees other than himself/herself and provides one or more of the following services: Attendant Care; Habilitation, Support; Housekeeping; Respite; or Habilitation, Individually Designed Living Arrangement.

---

**Section 6 Standard Terms & Conditions**
**Section 6.3.1 Records**

**Comment:**
*Can DDD please clarify the record retention period? Are providers required to keep all client records for as long as they serve the client, plus 6 years, or are they just required to keep records for 6 years from the current date? What are acceptable forms in which to keep the records?*

**Division Response:**
All records must be maintained for 5 years; except HIPAA records which must be maintained for 6 years. Providers must keep their client records during the period of time they serve the client and six years following the end of their service to that client or the end of their contract, whichever is longer. An acceptable form for records is any form that provides for an accurate and complete production or reproduction of the record.

This language is obtained from both the ADOA Uniform Terms and Conditions, 3.1; and the DES Terms and Conditions, 34.

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**Section 6 Standard Terms & Conditions**
**Section 6.3.2.4 Non-Discrimination**

**Comments:**
*Does this mean that this paragraph is to go on every single document that is given to the consumers/families?*
*Rather than require this language to be on every document used by the provider to convey information to the client, could it just be distributed at the annual ISP Meeting? A general form that conveys this information could be signed by the consumer or family or guardian once per year.*

*This is ridiculous it effectively adds an additional page to any brochure.*

**Division Response:**
This requirement is from the DES Special Terms and Conditions, revised 4/1/09.

Title II of the American with Disabilities Act of 1990 (ADA) applies to the programs and services of all state and local governments and their agencies and departments. It applies when programs and services are being provided directly by DES or its Divisions or are being provided by grantees or contractors. DES shall ensure that grantees and contractors understand their obligations under the ADA, inform individuals about their rights under ADA, and comply with the ADA. In addition, Section 504 applies to all of the operations of a department or agency of a state or local government that receives federal financial assistance (including Medicaid). DES grantees and contractors whose services are funded with federal financial assistance shall also comply with Section 504.

It is not the intent of this requirement for the referenced language to appear on every piece of paper (i.e. letter, memo) created by the Qualified Vendor. However, it is required on all publications, brochures, flyers and forms.

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**Section 6 Standard Terms & Conditions**
**Section 6.3.3.2 Audit (See Section 6.3.3, generally)**

**Comment:**
*Language concerning the Single Audit Act should be eliminated. The Single Audit does not apply to for-profit companies, and nonprofit companies are considered vendors, not sub recipients (per DDD ruling, at the time the QVA was first implemented).*

*Also, DDD is requesting an Audit Report and an Audit Opinion – these are one and the same. The opinion is contained in the Auditors' Report. The Management letter is now called the Memorandum on Internal Control. If there are no deficiencies or weaknesses, nothing is issued – communication to the Board of this fact is all that is required.*

*AAPPD objects to the requirement that this document be forwarded to DDD. It is meant as an internal memo only, to be used for management guidance.*

*I am not sure that the Single Audit Act has any applicability to programmatic monitoring.*

**Division Response:**
This section has been rewritten and no longer references the Single Audit Act.

If the Memorandum on Internal Control is issued by the auditor, then it will be required to be submitted as part of the Audit Opinion.

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**Section 6 Standard Terms & Conditions**
**Section 6.3.3.2.2 Audit (See Section 6.3.3, generally)**

**Comment:**
*Asking for separate reporting by divisions is not GAAP (Generally Accepted Accounting Principles). It would require supplemental schedules, and most auditors or accountants would indicate in their report that they do not express any opinion on these supplemental schedules, because no procedures have been performed and that they are there just for informational purposes. They would be extremely time intensive to prepare and since the auditors are not be required to opine on them they would not provide any additional assurances to DDD.*

**Division Response:**
This requirement has been eliminated.

---

**Section 6 Standard Terms & Conditions**
**Section 6.3.3.2.3 Audit (See Section 6.3.3, generally)**

**Comment:**
*One commenter strongly objected to submission of quarterly financial statements by providers. The submission of a preliminary audited financial statement (a draft) could create confusion and put information in outside hands that could not be controlled by the organization. Generally a draft does not include the auditors' report and is meant for discussion purposes only and is kept internally. DDD should wait for the final report to avoid confusion.*

*Our agency has not received a preliminary audited financial statement historically. Given the history we would not, or will not, be able to comply. With the auditing firms we have used, we have experienced 2 auditing cycles in which the 120 day requirement for following the end of the tax year would not have been met because of the auditors scheduling. I would suggest that the timeframe for submission be increased to 180 days.*

**Division Response*:***
Quarterly financial statements will be required from only those providers who receive in payment of services $5,000,000 or more from the Division each fiscal year. For FY 2010, this requirement would apply to 28 (4.5%) Qualified Vendors and represented about 50% of HCBS payments. The review of the qualified vendor financial statements is a part of the Division's analysis of HCBS network financial viability.

The requirement for submission of a preliminary audited financial statement (draft) has been eliminated.

The requirement for the submission of the audited financial statement to be due 120 days after the end of the tax year has been changed to 30 days after the completion of the audit.

---

**Section 6 Standard Terms & Conditions**
**Section 6.3.3.2.4 Audit (See Section 6.3.3, generally)**

**Comment:**
*The language is inconsistent with public accounting practice. Part (b) should read "Annual financial statements that have been reviewed by an independent financial accountant or agency".*

**Division Response**
The language referenced has been changed.

---

**Section 6 Standard Terms & Conditions**
**Section 6.3.3.2.5 Audit (See Section 6.3.3, generally)**

**Comment:**
*Indicates that these vendors may submit a compilation that has been reviewed by an independent financial accountant. The language is inconsistent with public accounting process; an accountant is not going to review a compilation. The language should state: "an annual financial compilation that has been compiled by an independent financial accountant or agency".*

**Division Response**
The language referenced has been changed.

---

**Section 6 Standard Terms & Conditions**
**Section 6.3.4 Notices**

**Comment:**
*Why are qualified vendors required to communicate with DDD concerning the contract solely in writing, when DDD may correspond via email?*

**Division Response:**
This section has been revised for clarity and correction. Email communication as an option for the Qualified Vendor has been added and a Division address has been provided for use by the Qualified Vendor unless a hard copy signature is required for specific documents.

---

**Section 6 Standard Terms & Conditions**
**Section 6.3.7.2**

**Comment:**
*If I understand this item it requires a Vendor which is no longer in business with the Division and may not be in existence to maintain consumer records for a period of 6 years. This may not be doable if a vendor is out of business.*

**Division Response:**
This is a standard requirement for all state contracts. See the State of Arizona Uniform Terms and Conditions, 3.1; and the DES Special Terms and Conditions, revised 4/1/09, 34 et. seq.

---

**Section 6 Standard Terms & Conditions**
**Section 6.4.1.1 Payments**

**Comment:**
*Section 6.4.1.1 states "upon delivery of goods or services, the Qualified Vendor shall submit a complete and accurate invoice to be paid by the State up to and including 30 days after receipt by the State of an accurate invoice from the Qualified Vendor."*
*This sentence is very awkward and should be restated. What does this mean?*

**Division Response:**
This section means that the state has up to 30 days to pay the Qualified Vendor after receipt of an accurate and complete invoice (clean claim), and is based on the Uniform Terms and Conditions for payments that states:

"Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of goods or services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days."

**Comment:** *Will DDD continue to pay invoices for less than $50K upon receipt instead of the 30-day delay?*

**Division Response:**
This section does not change the DES/DDD current payment processing procedures; however, as the contract language states, the Department has thirty (30) days to pay a complete and accurate invoice.

---

**Section 6 Standard Terms & Conditions**
**Section 6.4.3 Availability of Funds**

**Comment:**
*Does the word "adjust" allow DDD to retroactively revoke authorizations?*
*Does "adjust" prior authorizations imply retroactive revocation?*

**Division Response:**
The ALTCS program requires that prior authorizations be based on medical necessity. The ISP team makes recommendations while the Division maintains the final responsibility to ensure services are medically necessary. If a current level of service is to be reduced, the Division must follow due process timelines before the service reduction can take place. This requirement is not intended to by-pass an individual's right to due process under 42 CFR 438.404.

As stated in the DES Special Terms and Conditions, revised 4/1/09:

**3.0 Availability of Funds.**

3.1 The Department may reduce payments or terminate this contract without further recourse, obligation or penalty in the event that insufficient funds are appropriated or allocated. The Director of the Department shall have the sole and unfettered discretion in determining the availability of funds. The Department and the Contractor may mutually agree to reduce reimbursement to the Contractor when the payment type is Fixed Price with Price Adjustment by executing a contract amendment.

The Division has revised the section for clarity as follows:

> The State shall have no liability for any payment that may arise under this Agreement beyond the current fiscal year until funds are made available for performance of this Agreement. The Department may adjust payment authorizations as to services not yet delivered, adjust prior authorizations as to services not yet delivered, or terminate this Agreement, in whole or in part, without further recourse, obligation or penalty as to services not yet delivered in the event that sufficient funds are not available.

---

**Section 6 Standard Terms & Conditions**
**Section 6.4.6.1 Level of Service**

**Comment:**
*One commenter objected to the language in this section ". . . this Agreement is for the sole convenience of the Department". Providers believe the Agreement is for the enhancement of the lives of people with developmental disabilities. Providers are concerned about this language which seems to imply a very unilateral approach to the contract and amendments.*

**Division Response:**
This is a required term from the DES Special Terms and Conditions, revised 4/1/09:

21.2 The Department makes no guarantee to purchase specific quantities of goods or services, or to refer eligible persons as may be identified or specified herein. Further, it is understood and agreed that this contract is for the sole convenience of the Department and that the Department reserves the right to obtain like goods or services from other sources when such need is determined necessary by the Department.

---

**Section 6 Standard Terms & Conditions**
**Section 6.4.6.4 Level of Service**

**Comment:**
*There are many situations in which a vendor might not be able to provide 60 day notification, such as the family moving.*

*I am not sure what is to be included in "emergency" but as a residential service provider we have experienced consumers leaving the agency to relocate and have done so without a 60 day notice to us. This requirement should be restated to be "as soon as it is known".*

**Division Response:**
The emergency exception should cover those circumstances when 60 day notification is not possible.

---

**Section 6 Standard Terms & Conditions**
**Section 6.4.8.1 Reporting Requirements**

**Comment:**
*15 days is not adequate to prepare and submit required reporting. The requirement should be 30 days.*

**Division Response:**
The language referenced has been changed to reflect 30 days.

---

**Section 6 Standard Terms & Conditions**
**Section 6.5.2.2 Qualified Vendor Code of Conduct**

**Comment:**
*What precipitated inclusion of this section? The language is very nonspecific, very subjective, and these items are already in statute, code, etc.*

*The fourth requirement specifies that providers must ensure that all employees have been trained and understand all applicable laws concerning confidentiality. This component will require vendors to be trained to understand federal, state and applicable rule in addition to agency policy. I believe that it is reasonable to request training in policy with regard to confidentiality and acknowledge the training by written affirmation. I do not believe that training in federal or state law is necessary or prudent. If the policy is sound and based upon meeting the legal requirements this should get to the same end.*

*The seventh bullet should be struck. Even though I would agree that this is a positive trait, I do not believe that it is a code that is universally found nor do I believe that as an employer I can use this as an actionable item.*

**Division Response:**
This provision is required for all DES contracts.

---

**Section 6 Standard Terms & Conditions**
**Section 6.5.3.1.6 Central Registry (See Sections 5.1.11; 6.5.5 & 6.8.2.16.1)**

Please Note: All questions and comments regarding the Central Registry, along with the Division responses were included in Section 5.1 Provider Qualifications, No. 11 Central Registry of this document.

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**Section 6 Standard Terms & Conditions**
**Section 6.5.4.1 Fingerprinting**

**Comment:**
*In Section 6.5.4.1.1, consider clarifying that all people who provide services to people with developmental disabilities must be fingerprinted. The language about juveniles and the absence of language about adults makes this section confusing.*

*6.5.4.1.5, These line items keep referring to the need to fingerprint those who provide services to juveniles. The Article 8 Program Monitor Rules mandate fingerprinting for all direct care staff whether working with juveniles or adults. This needs clarification.*

**Division Response:**
The provisions in A.R.S. § 41-141 will be applied to vulnerable adults as well as juveniles under this agreement.

---

**Section 6 Standard Terms & Conditions**
**Pages 6-16 &6-17**

**Comment:**
*There are issues with the numbering of the sections on these pages (6-16 & 6-17). There are two 6.5.4 sections, and the numbering is not chronological.*

**Division Response:**
This was an error. This was renumbered correctly.

---

**Section 6 Standard Terms & Conditions**
**Section 6.5.7.3 Monitoring (See Section 6.5.10.3)**

**Comment:**
*This section requires the Vendor to notify all current and prospective clients that it is operating under a corrective action plan, if the plan requires it. Sometimes, corrective action plans are issued for relatively minor issues. In practice, notification is only done when a "Notice of Cure" has been issued. Will there be a change in this practice? If not, the language should be changed to reflect the practice.*

**Division Response:**
The Division has revised this section to read:

If the Division requires the Qualified Vendor to implement a corrective action plan, and if the **approved** plan requires it, the Qualified Vendor shall notify all current and prospective consumers that they are operating under a corrective action plan.

---

**Section 6 Standard Terms & Conditions**
**Section 6.5.9.1 (See Section 6.5.12)**

**Comment:**
*Sanctions imposed against the Division by AHCCCSA for noncompliance with requirements for encounter data reporting, referenced in "Records" of these Terms and Conditions, that would not have been imposed but for the Qualified Vendor's action or lack thereof will be assessed dollar for dollar against the Qualified Vendor. I do not understand what this item is other than if AHCCCSA isn't happy then I may be sanctioned as a Vendor. This needs real clarification.*

**Division Response:**
This states that if AHCCCS imposes a sanction against the Division as the direct result of an act by a Qualified Vendor, the sanction will be passed to the Qualified Vendor by the Division.

AHCCCS could potentially sanction the Division for continued non-compliance of service delivery, as an example of a Qualified Vendor's lack of timely response to consumers when a gap in service delivery exists. AHCCCS would first issue a Notice to Cure and continued non-compliance would lead to a sanction, including a financial sanction. If the Division worked with and notified the Qualified Vendor(s) of the action causing non-compliance; the Division could pass along the sanction to the Qualified Vendor(s). The section has been revised to reflect that the Qualified Vendor is only responsible to reimburse the Division for the portion of the sanction that is attributable to the Qualified Vendor's action or inaction.

---

**Section 6 Standard Terms & Conditions**
**Section 6.5.10.1 (Section 6.5.13)**

**Comment:**
*I do not believe that it should be the Qualified Vendor's responsibility to receive grievances from the consumer regarding service ineligibility determinations or service reductions if the vendor is not the initiator of the action.*

*It is also inappropriate for a Vendor to field and forward any of the aforementioned grievances to the Division.*

**Division Response:**
This is governed by the current AHCCCS/DES/DDD Contract (YH6-0014). The contract can be viewed at http://www.azahcccs.gov/commercial/Purchasing/contracts.aspx

The grievance process is required in 42 CFR Sec. 438 to ensure consumers' rights are being protected.

---

**Section 6 Standard Terms & Conditions**
**Section 6.7.6.1.1 Indemnification**

**Comment:**
*This section requires subcontractors to be insured at the same level as the qualified vendor, but policies do not allow the insurance coverage to pass through. This applies to "contracted employees", as well as other subcontractors. How does DDD plan to enforce this?*

**Division Response:**
This is governed by the current AHCCCS/DES/DDD Contract (YH6-0014). The contract can be viewed at http://www.azahcccs.gov/commercial/Purchasing/contracts.aspx
This provision will be enforced in the same manner as any other contractual provision.

---

**Section 6 Standard Terms & Conditions**
**Section 6.8.1 Warranties (Year 2000)**

**Comment:**
*Is section, dealing with Y2K, still necessary?*
*This section seems to be an anachronism.*

**Division Response:**
The Division has been informed that the Y2K provision is still required until the State's Uniform Terms and Conditions are amended. Portions of the provision apply to the leap years and years between the 20th and 21st century, and are, therefore, still applicable.

---

**Section 6 Standard Terms & Conditions**
**Section 6.8.2.12 (See Section 6.8.2.11)**

**Comment:**
*Please include language that better defines what "service standards or guidelines" refer to in this section.*

**Division Response:** This section requires the qualified vendor to comply with all requirements of law, including agency administrative rules; agency policies and procedures; and the service standards or guidelines that apply to the service being provided by the qualified vendor. "Service standards and guidelines" refer to the professional standards and guidelines that apply to the provision of professional services. This section was clarified.

---

**Section 6 Standard Terms & Conditions**
**Section 6.8.2.16.2 Compliance With Applicable Laws (C.F.R. §1001.1901(b)**

**Division Response:**
This section was added after the public comment period. It is a federal requirement. Qualified Vendors can search the HHS-OIG website (http://www.oig.hhs.gov/fraud/exclusions.asp) at no cost. One Qualified Vendor has discovered a company who will provide these staff background checks for about $500 a year, EPStaff Check (http://www.EPStaffCheck.com). The Division has not verified this information concerning EPStaff Check, and this response is not an endorsement of this company. There may be other similar resources available to employers.

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**Section 6 Standard Terms & Conditions**
**Section 6.8.2.17.2 Compliance With Applicable Laws (Central Registry)**
**(See Section 6.5.5 & Section 6.8.2.16.1 and Section 5.1.11)**

**Comment:**
*See Section 5.1 No. 11 above. Also, it appears that a 30 day window is being allowed to submit all current employees for the Central Registry Check. We assume that there is an exception to the provision that individuals may not provide direct services until the results of the background check are complete. Could this exception be included in this section?*

*I am wondering why there is a requirement to submit the "Request for Search of Central Registry on all employees 60 days prior to the end of the agreement?*

*It's financially and practically impossible to hire someone and not allow them to work direct service until the results of their background check come back. Who is going to pay for these two required extra background checks a year?*

**Division Response:**
The contract has been revised to delete references to the processes to comply with the Central Registry requirements. Separate instructions will be provided with the application.

---

**Section 6 Standard Terms & Conditions**
**Section 6.8.3 Advance Directives**

**Comment;**
*This section requires Qualified Vendors to comply with advance directives, such as "do not resuscitate" orders (DNRs) for adult clients. Providers object strongly to this requirement because their employees are not medical personnel who are trained and experienced in making decisions on giving or withholding medical care.*

**Division Response:**
The vendor is only required to indicate whether or not an advanced directive has been created. DDD modified the term "executed" to "created."

---

**Section 6 Standard Terms & Conditions**
**Section 6.8.4.6.3 Group Home for Juveniles (Corrective Action Plan)**

**Comment:**
*Section 6.8.4.6.3 requires a corrective action plan to be implemented immediately. Previous language allowed for up to 90 days. Why has this been changed? We suggest the language be changed to "in an appropriate amount of time, not to exceed (date specific)."*

**Division Response:**
This was revised to include the implementation date as part of the corrective action plan.

---

**Section 6 Standard Terms & Conditions**
**Section 6.8.6 (Suspension or Debarment) & Section 6.10.3 (Suspension or Debarment)**

**Comment:**
*Section 6.8.6 and Section 6.10.3 are in essence the same requirement regarding debarment/suspension. It is suggested that one of these could be removed. The same applies to the statements regarding termination in Section 6.10.6 and Section 6.10.6.4. The statement in Section 6.10.6.4 merely repeats the final statement in Section 6.10.6 so it could also be removed.*

**Division Response:**
These sections were combined into one section.

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**Section 6 Standard Terms & Conditions**
**Section 6.9.2.1**

**Comment:**
*Section 6.9.2.1"requires the Qualified Vendor to stop all or any part of the work called by this Agreement for a period(s) of days indicated by the state. . . and take all steps to minimize the incurrence of costs allocable . . ."*

*How does this happen in residential? Shouldn't the contract make except "residential" notation?*

**Division Response:**
This is a DES Standard Term and Condition that applies to all services, including residential.

---

**Section 6 Standard Terms & Conditions**
**Section 6.10.6 & Section 6.10.6.4 (See Section 6.8.6)**

**Comment:**
*The statement in Section 6.10.6.4 merely repeats the final statement in Section 6.10.6 so it could also be removed.*

**Division Response:**
These sections have been revised to remove the duplications.

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**Section 6 Standard Terms & Conditions**
**Section 6.10.6 Termination for Default (See Section 6.10.5)**

**Comment:**
*Providers would like this section to include notice and an opportunity to cure the situation, prior to termination of the agreement, in whole or in part.*

**Division Response:**
This is a provision in the DES Standard Terms and Conditions, revised 4/1/09.
The Division's current practice is to not initiate any termination without utilizing corrective action processes already in place, such as the Notice to Cure and Demand for Assurance which occurs prior to an action to terminate.

See also A.A.C. R6-6-2111. Termination of the Qualified Vendor Agreement, for additional authority for this provision.

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**Section 6 Standard Terms & Conditions**
**Section 6.10.7 Continuation of Performance Through Termination**
**(See Section 6.10.6)**

**Comment:**
*Providers object to the requirement to perform past the end of the Agreement. If there is specific reporting requested, this should be expressly written.*

*I disagree with this item. If there is no business relationship in existence I believe that it is unfair and inappropriate to expect the Vendor to continue to perform. I would suggest that this section be removed.*

**Division Response:**
This provision exists to protect consumer's health and safety in order to transition responsibilities for consumers from an exiting vendor to a receiving vendor. This process does not require specific reports, but all requirements specific to any termination shall be set forth in the termination notice.

---

**Section 6 Standard Terms & Conditions**
**Section 6.10.8.3.9 Termination for Any Reason (See Section 6.10.7.1)**

**Comment:**
*This section should be struck. Once the contract has been terminated, DDD should not expect additional financial information or any other action.*

*Request that the timeframe for submission be changed from the 5th day of the following month to the 15th day to make this requirement more feasible to comply.*

**Division Response:**
This requirement is from the DES Special Terms and Conditions, revised 4/1/09.

34.3.1 If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination.
34.3.2 Records which related to disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by the state, shall be retained by the Contractor until such disputes, litigations, claims or exceptions have been disposed of.

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**Section 6 Standard Terms & Conditions**
**Section 6.12 Contingency Planning**

**Comment:**
*The requirements of this Section imply that the effects of a disaster can be avoided, or at least mitigated, if enough planning is done ahead of time. These requirements instill a false sense of security and increase the burden on providers who are already drowning in reporting and training requirement, and a 10% rate reduction on rates that are 3 years old. It is requested that this entire section be removed from the agreement as a requirement.*

**Division Response:**
This is a mandatory Arizona Department of Administration requirement in all state contracts.

Section 6.12 is an acknowledgment that disasters cannot be avoided but providers should be prepared to respond appropriately in the best interest of the consumers. Section 6.12 simply outlines expectations that providers plan and prepare for how to respond if a disaster occurs.

Recently the Division has had experience with the massive fires and flooding requiring temporary relocation of consumers in Flagstaff. The planning and preparation that was demonstrated by the district staff and provider community during these disasters was evident. Staff, at all levels, considered the health and safety of the individuals and evacuation plans were implemented. Where problems were identified corrective plans were requested so if future disasters occur staff will be better prepared.

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**Section 6 Standard Terms & Conditions**
**Section 6.14.1 Inclusive Qualified Vendor (See Section 6.13.3.1)**

**Comment:**
*This section requires the provider to "make every effort" to utilize subcontractors that are small, women-owned and/or minority owned businesses. Providers are concerned that the word "every" is too onerous, and should be changed to list the specific actions DDD would like to have take place.*

**Division Response:**
This term is required by Executive Orders 2000-4 and 2003-09 which impose specific requirements on state agencies to procure from small and women and minority-owned businesses "whenever practicable," and implement a system to track the award of contracts to these entities.

The language of the RFQVA provision is adapted from DES Special Terms and Conditions 19.1.

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**Section 7 Service Specifications**
**Attendant Care**

**Comment:**
*Under Service Requirements and Limitations (page 1), No. 2 does not allow the service to be provided in the provider's home. The current specifications state that the service can be delivered in the individual's community, which has been interpreted to include the provider's home when the Qualified Vendor has a provider with a licensed home who provides respite, and also provides a shower, laundry, feeding etc. while the consumer is in the provider's home. As long as the agreement is being met, why is DDD restricting where the service can be provided? What about for AFC – isn't that provided in the provider's residence?*

**Division Response:**
Attendant Care includes such services as grooming, housekeeping, etc. It is difficult to understand how or why these services would need to be provided outside the consumer's typical environments. Cleaning a consumer's home, performing bathing supports and related activities should be completed where the consumer would otherwise typically have those services performed. The community outside the consumer's home where these services would otherwise be necessary are still acceptable; however, the intent is for the service to be provided in that environment where the consumer would otherwise need the assistance (laundry mat, grocery store, etc).

While attendant care provided by a family member may be the "provider's home," it would also be the consumer's home or a place the consumer regularly visits.

---

**Comment:**
*Under Service Requirements and Limitations (page 1), No. 3, won't AFC, by definition, supplant care provided by the consumer's natural supports? What is the criteria for natural supports and how much natural supports should be doing and how much service is needed?*

**Division Response:**
The care provided by a family member is determined by first completing an assessment as to the hours of support needed by the consumer and then determining who will provide the care. The assessment process determines what can and should be provided by the natural family and what supports are needed to be provided outside those natural supports.

---

**Comment:**
*Service Requirements No. 7 (page 1) states housekeeping is only to be done for the consumer and in shared areas of the home, but in No. 7.6 in Service Objectives (page 3), the term "household supplies" implies supplies for the entire household. This should be clarified.*

**Division Response:**
The Service Objective 7.6 has been clarified to reflect "household supplies" used by the consumer.

---

**Comment:**
*Service Requirements No.10 (page 1) – direct service provider's relationship to consumers. For what reasons does the Qualified Vendor / Division need to know this information?*

*One provider suggested changing the language to – the Qualified Vendor shall require direct care providers to disclose familial relationships and maintain data.*

**Division Response:**
Disclosure of the family relationship regarding direct service providers to the consumer is required for the billing of attendant care services to identify the appropriate billing modifier to ensure proper payment for these services.

---

**Comment:**
*Service Requirements No. 11 (page 1) – spouse as a direct service provider. Please add clarification that consumer's who have a spouse as a provider may not have more than 40 TOTAL hours of service per week.*

**Division Response:**
According to the AHCCCS Medical Policy Manual, Chapter 1200, Section 1240, on page 1240-10, the spouse providing attendant care services as a paid caregiver shall not be paid for more than 40 hours of services in a seven day period.

AHCCCS Medical Policy Manual 1200 further clarifies the following: For a member who elects to have his/her spouse provide attendant care services as a paid caregiver, attendant care or similar services (e.g. personal care and homemaker), in excess of the 40 hours are not covered regardless of whether the services are provided by the spouse as paid caregiver or provided by the spouse in combination with an agency caregiver or an AHCCCS registered independent caregiver.

However, by electing to have the member's spouse provide attendant care services as a paid caregiver, the member is not precluded from receiving medically necessary, cost effective home and community based services other than attendant care or similar services (e.g. personal care and homemaker) as described in the "amount, duration and scope" section of the attendant care policy. Members are eligible for respite care services subject to applicable limitations as noted in the respite care services.

---

**Comment:**
*No. 12 (page 2) indicates that a site visit would be required for each new staff member. This would be costly and time-consuming. Can this requirement be reduced, especially for AFC? It does not seem necessary to visit quarterly when mom or dad is providing the service. Also, is the 90 visit requirement the same as the 90 ISP review? If not, it is redundant.*

**Division Response:**
This is a mandatory requirement specified in the AHCCCS Medical Policy Manual, Chapter 1200, and Section 1240 on page 1240.2. This is not a new requirement for Qualified Vendors. The requirement states: "This type of supervisory visit must be initiated not more than five days from the day the initial service provision began (not every time the employee changes). A follow up site visit is required at 30 days. A 60 day visit is required if issues are identified, otherwise visits are required at least every 90 days thereafter (more often as indicated)." The 90 day visit requirement is not the same as the 90 day review, although both could occur on the same day.

---

**Comment:**
*Under Service Goals and Objectives, Service Objectives, (page 2), No. 1 requires the Qualified Vendor to develop and implement a schedule and general plan of care (Attendant Care Agreement). It would seem more logical for the support coordinator to complete this form, in order to determine how many hours of service to authorize.*

**Division Response:**
The support coordinator is responsible for developing the general plan of care. This section has been revised to reflect this requirement.

---

**Comment:**
*In Service Objectives (page 2), the Qualified Vendor is required to develop a general plan of care, but on page 3 under Service Utilization Information, the ISP Team is supposed to assess the needs of the client. Isn't this contradictory?*

**Division Response:**
The service objective requiring the Qualified Vendor to develop a general plan of care has been revised. The support coordinator, in conjunction with the ISP team, develops the plan of care. The provider contributes to the implementation of the care plan.

---

**Comment:**
*No. 7.2 in the Service Objectives (page 3) requires the oven and refrigerator to be cleaned, but not the stove and microwave. This seems arbitrary.*

**Division Response:**
The language has been revised to include other appliances.

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**Comment:**
*No. 7.3 in this section (page 3) requires providers to assist to attain or maintain safe and sanitary living conditions, including "routine maintenance" of household appliances. Although this is also in the current specs, providers believe it needs to be clarified to ensure they aren't required to pay for expensive repairs, such as an electrician to have a refrigerator repaired.*

**Division Response:**
The language in this section has been revised to clarify that the Qualified Vendor is not required to pay for repairs.

---

**Comment:**
*Under Recordkeeping and Reporting Requirements (page 5), No. 7, can DDD clarify the requirements for the monthly attendant care reports? Very few support coordinators request them. Is it necessary to require both these reports and the monitoring visits?*

**Division Response:**
The requirement for monthly attendant care reports has been eliminated.

---

**Comment:**
*Is there certification for all staff?*

**Division Response:**
Certification requirements for home and community based service providers, such as attendant care providers, are found in the Arizona Administrative Code, Title 6, Chapter 6, Article 15.

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**Section 7 Service Specifications**
**Center Based Employment**

**Comment:**
*Should the terminology in this section be changed to "paid training", rather than "remunerative work" to conform to language used by the Industrial Commission?*

**Division Response:**
"Remunerative work" is in the Arizona SFY 2010 Dictionary and Taxonomy of Human Resources and cannot be removed by the Division of Developmental Disabilities; however, the RFQVA specification was changed to add the term "center based employment and made references to paid employment throughout the employment specifications.

---

**Comment:**
*The use of the term "sheltered workshop" is antiquated, and has not been used to describe a community rehabilitation program for 20 years. It is derogatory and negatively reflects on the services provided. This should be replaced with center-based program or organizational employment services.*

**Division Response:**
"Sheltered workshop" is in the Arizona SFY Dictionary and Taxonomy of Human Resources, which cannot be deleted by the Division of Developmental Disabilities; however, the RFQVA service specification was changed to add information about center based employment.

---

**Comment:**
*Under Service Outcomes (page 2) No. 3, there is a requirement for identifying 10% of consumers for progressive moves from center-based employment within the next 6 months. What occurs after this process?*

**Division Response:**
The teams for these individuals would meet to discuss referrals to a progressive employment such as to Group Supported Employment or Individual Supported Employment.

---

**Comment:**
*What if the 10% don't move?*

**Division Response:**
There is no penalty to the Qualified Vendor if 10% of the individual don't move; the Division would assess the reason for the lesser number of progressive moves and work

with the vendor and the individuals, along with their teams, to develop additional strategies to increase progressive moves.

---

**Comment:**
*What if a consumer doesn't want to move?*

**Division Response:**
The choice of the consumer is part of the ISP team planning. Consumers should be presented opportunities to learn more about employment in the community as part of thinking about their choices.

---

**Comment:**
*Is there additional reporting?*

**Division Response:**
There is not additional reporting and these requirements have been reduced. The monthly individual progress reports are now quarterly.

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**Comment:**
*Are there additional dollars to support more involved clients in more integrated settings?*

**Division Response:**
The current service specifications and rate structure address the costs of supporting consumers in more integrated settings. For more information on how to use the specifications and rates to assist in the development of employment opportunities, feel free to contact the Division at DDDHotline@azdes.gov

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**Comment:**
*Under Service Utilization Information (page 3), No. 3, the specifications state, that CBE will only be provided to consumers who are 22 years of age or older. Why are consumers eligible for DTA at 18, but not for CBE until 22?*

**Division Response:**
Thank you for your question and comment. It is preferable for most young adults to stay in school until they are 21 in order to gain additional academic, social and community skills that form the platform for future successful employment. There will be further review of the age by which young adults enter DTA, not just CBE. At the current time, those that enter center based at age 22 have had the benefit of these extra foundational years.

---

**Comment:**
*What happens to consumers who graduate before they are 22?*

**Division Response:**
The service specification does allow someone younger than 22 to enroll in a Center Based Employment program with their ISP team's recommendation and the Division's district management approval. The Division encourages young adults graduating sooner than age 22 to take advantage of a referral to Rehabilitation Service Administration/Vocational Rehabilitation and subsequent participation in Group Supported Employment or Individual Supported Employment as an initial option to Center Based Employment.

---

**Comment:**
*Under Direct Service Training Requirements (page3), having a copy of the training materials available for review should be sufficient. Where can providers find the curriculum approved by AHCCCS and the Division, as referenced?*
*Under Recordkeeping and Reporting Requirements (page 4), No. 5, a quarterly report is required. Does this take the place of the 6 month report? What is the format?*
*The vendor already submits monthly, individualized progress reports for each consumer. Any additional reporting should be eliminated. Providers do not have the resources to produce repetitive information.*

**Division Response:**
The Qualified Vendors will submit progress reports on a quarterly basis.
Training requirements are set forth in other sections of this document. See § 5.

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**Comment:**
*Under Recordkeeping and Reporting Requirements (page 4), No. 5, a quarterly report is required. Does this take the place of the 6 month report? What is the format? The vendor already submits monthly, individualized progress reports for each consumer. Any additional reporting should be eliminated. Providers do not have the resources to produce repetitive information.*

**Division Response:**
The requirement to submit monthly progress reports has been changed to a quarterly report. The quarterly reports are individual consumer-specific; the 6 month report is an aggregate report. The former is intended to be used by individual support coordinators to document progress toward the consumer's outcomes for the specific service. The aggregate report is an agency-wide report of progress toward program outcomes. Each report serves a distinct purpose. The format of the reports can be jointly developed to minimize redundancies. The Division will continue to work with providers to eliminate/consolidate reporting requirements.

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**Section 7 Service Specifications**
**Day Treatment & Training Adult**

**Comment:**
*In Service Requirements and Limitations, (page 1), No. 4 indicates that consumers must be supervised by paid Qualified Vendor staff. Is there a prohibition against a volunteer working in this capacity, as long as they have been appropriately cleared through the fingerprinting and child abuse registry?*

**Division Response:**
There is no prohibition of using a volunteer and the Division welcomes the participation of community partners provided that they have met the requirements of direct service staff and are supervised by the Qualified Vendor.

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**Comment:**
*In Service Objectives (page 2), No. 1.2 requires development of strategies for habilitative functional outcomes within 10 business days. Ten days may not be sufficient time to learn the consumer's wants/needs well enough to develop effective strategies. For consumers that have transferred from another program, most ISP teams expect to have a "transfer teaming" after the first 30 days. This would be a more realistic timeframe.*

**Division Response:**
If the team believes that additional time is required, this need can be documented and implemented through the ISP process.

---

**Comment:**
*In Service Objectives (page 3), No. 7, there is a requirement for a monthly on-site schedule of daily activities, prepared with consumers' direct input. It may not be possible for some consumers to give meaningful input with this timeline.*

**Division Response:**
This is an objective that should be implemented when practicable, and documented in the ISP when it is not practicable.

---

**Comment:**
*Service Objectives (page 3), No. 9, states that day programs should, when appropriate, include work-related activities. This appears to replace the previous language "provide consumers opportunities to earn money as part of habilitative learning objectives". What will happen to programs which allow day program consumers to go to employment programs for a few hours a week? Will day program clients be forbidden to earn money?*

**Division Response:**
Day programs are not a substitute for employment services, but it is not the intent of the Division to prevent paid work opportunities when such activities are part of a consumer's habilitative learning objective.

---

**Comment:**
*In Service Utilization Information (page 3), No. 1, providers still need the ability to bill for an aide, when needed, during transport due to safety.*

**Division Response:**
This is built into the cost of regularly scheduled transportation rates. However, if there is a special circumstance that requires the services of an aide, the ISP team can document the need and obtain appropriate authorization approval.

---

**Comment:**
*Under Recordkeeping and Reporting Requirements (pages 4, 5), No. 2, the provider is required to send monthly progress reports to the consumer/family/consumer's representative. This should include the phrase "if requested". Many families, guardians, public fiduciaries, etc., do not want this information, and it expensive for the provider to copy and send it. It is always available upon request.*

**Division Response:**
The requirement for progress reports has been changed from monthly to quarterly reports for day treatment and training (adult). In addition, this service specification has been revised to require that the progress reports be provided upon request.

---

**Comment:**
*Recordkeeping and Reporting Requirements (page 5) No. 4, state that "only the time when consumers are present at the program shall be counted as direct service." Does this change the half hour leeway allowed for transportation issues when another provider or the family transports the client?*

**Division Response:**
*No, the half-hour leeway is defined in the RateBook and is not changing.*

---

**Comment:**
*Recordkeeping and Reporting Requirements (page 5) No. 5, states "the Qualified Vendor shall have a monthly schedule of planned activities posted at all times." For some people with disabilities, especially autism, having an activity posted causes a lot of stress and OCD behaviors. We suggest that "shall" be changed to "should", allowing the leeway for providers to act in the best interest of the people they are serving.*

**Division Response:**
The provider should post the schedule in a location that is appropriate for the consumers being served. For community based programs that do not have a facility based program, monthly schedules should be available.

---

**Section 7 Service Specifications**
**Day Treatment & Training – Child Summer**

**Comment:**
*In Service Objectives, (page 2), No.2 specifies that the provider is responsible for ensuring that the health needs of the client are met and implementing therapeutic recommendations. These are objectives better met by the parent, and trained therapists. If these objectives are to remain, they should be more clearly defined as to what the provider's responsibility is, especially considering a 1:4 staff to client ratio.*

**Division Response:**
This program is authorized as medically necessary, and is considered to be habilitative in nature. This objective places responsibility with the provider when providing service.

---

**Comment:**
*No. 8 in this section also requires the day treatment provider to play an active role in ensuring that services with other involved entities are coordinated. The exact responsibilities should be spelled out. This appears overlap with the job of the support coordinator and the parent(s).*

**Division Response:**
The active role is to participate as necessary to ensure coordination of all services as appropriate.

---

**Comment:**
*In Service Objectives (page 3), No. 10, there is a requirement to partner with the Division to conduct program reviews, etc. Is this the 90 day review, or in addition to that? If it is not the 90 day review, this should not be implemented at this time. Providers do not have the resources to support additional unnecessary procedures.*

**Division Response:**
The Qualified Vendor is required to partner with the Division to conduct program reviews. This is the Division's 90 day ISP review process. Additional reviews may be conducted as needed which is determined by any member of the ISP team requesting additional review.

---

**Section 7 Service Specifications**
**Group Supported Employment**

**Comment:**
*Should the terminology in this section be changed to "paid training", rather than "remunerative work" to conform to language used by the Industrial Commission?*

**Division Response:**
"Remunerative work" is in the Arizona SFY 2010 Dictionary and Taxonomy of Human Resources and cannot be removed by the Division of Developmental Disabilities; however, the RFQVA was changed to make references to paid employment throughout the employment specifications.

---

**Comment:**
*In the Service Objectives section (pages 1, 2), No. 6 should be written so that it is clear that the intervention and technical assistance is provided for the consumer, not the employer.*

**Division Response:**
This objective *is* intended to allow provision of supports and technical assistance to the employer to the benefit of the consumer as needed to support the success of the consumers at the job. The Division has revised this objective for clarification.

---

**Comment:**
*In the Service Objectives section (pages 1, 2), No 9 states that the provider is responsible for ensuring the ongoing availability of remunerative integrated work in an amount adequate to the number of consumers in the program. We suggest that this be restated to "the Qualified Vendor will monitor availability of remunerative work . . . and/or will consider other options with the team if availability of remunerative integrated work falls below 75% of time the consumer spends on the job.*

**Division Response:**
Monitoring the amount of work available and developing new opportunities are inherent responsibilities in the provision of group supported employment. If the amount of work the group is doing doesn't support the number of consumers on the "crew," then the provider is to make the necessary corrections by finding ways to either obtain more work or exploring other options such as decreasing the size of the work crew.

---

**Comment:**
*Under Service Outcomes (page 2), No. 2 requires the provider to identify at least 10% of consumers served for progressive movement. This is not realistic or practical. GSE is provided to people whose maximum efforts result in minimal productivity. The large majority of the people served do not have the skills to maintain employment without the*

*constant, ongoing support of staff trained in the DDD field and dedicated solely to their success, and employers do not have the patience or resources to provide this support.*

**Division Response:**
Many consumers in Arizona who have worked in Group Supported Employment have moved on to individual jobs. The Division considers this to be a reasonable expectation and more individuals and their families are expressing increased interested in individual employment. This expectation should be present for the consumers who want to work and have shown progress and potential to do so. Consumers, families, friends and paid providers are increasingly working together to recognize and support growth and greater independence. Data from the Qualified Vendors will allow the Division and teams to assess whether this service outcome is practical as we work together to further employment outcomes.

---

**Comment:**
*In the Service Utilization Information section (pages 2, 3), No. 3 dictates that no more than one group shall be co-located in a physical location without prior approval, but some large sites can require 2 crews.*

**Division Response:**
There is no prohibition to have 2 crews co-located; all that is needed for this is pre approval assure that the co-location of two crews meets the definition of an "integrated setting."

---

**Comment:**
*In the Service Utilization Information section (pages 2, 3), No. 4 requires services to be provided to consumers over the age of 18, but there are a lot of 16 and 17 year old consumers who would benefit from summer jobs. Group supported employment can be a great way to start them.*

**Division Response:**
Participation of individuals younger than 18 is not prohibited. Because it is not the intent of the Division to supplant the responsibilities of the local school districts, District management approval is required. The Division supports an increasing number of young adults in employment services in lieu of Day Treatment and Training services during school summer breaks. What is ideal, is when school districts provide school sponsored experiences identified through the student's IEP in day treatment programs. There are schools that provide for this already and this is encouraged when possible and appropriate.

---

**Comment:**
*Under Recordkeeping and Reporting Requirements (page 5), No. 5, a "comprehensive consumer status report using Division forms" is required. Why the discrepancy in reporting requirements between this service and center-based employment? Monthly reports are already generated. Providers do not have time and resources to generate repetitive information.*

**Division Response:**
The Center Based Employment requirement has been revised to address the discrepancy as appropriate.

The monthly progress reports are now quarterly reports that are individual consumer-specific; the 6 month report is an aggregate report. The former is intended to be used by support coordinators to document progress toward the individual consumer's outcomes for the specific service authorized. The aggregate report is an agency-wide report of progress toward program outcomes. Each report serves a distinct purpose. The Division will continue to work with Qualified Vendors to identify and eliminate unnecessary reporting.

---

**Section 7 Service Specifications**
**Habilitation, Group Home**

**Comment:**
*This provider agency is extremely concerned about the specifications for Group Home Habilitation. The specs appear to address only clients who are eligible for Community Protection Hab. The old group home specs seem to align with Developmental Homes now.*
*There is great concern that the contract specifications seem to be oriented toward a community protection client, rather than the average group home client, and the description of a typical group home client is moved to developmental homes. Does this reflect a change in placement protocol within DDD? What are the client criteria referenced for Community Protection and Treatment? Is this all intentional?*

*DDD has not taken into account exceptional cases such as a client who has been hospitalized, then comes home on oxygen, for which the provider has no experience or training. This cannot wait for an ISP Meeting; the client's needs must be met immediately. The responsibility falls to DDD in these emergent situations to determine proper placement.*

*The language states "the published rate is based on 1 hour of direct service". Shouldn't this be "1 day of direct service"?*
*"An individual present at 11:59 pm may be billed for on that calendar day."*

*"The authorized staffing for each residence is codified by a written agreement by the District Program Manager/Designee and the Qualified Vendor; will this no longer be determined by the ISP team"? ARS 36.582 has always seemed ambiguous.*

**Division Response:**
The Division has revised this service specification for clarity.

The language does indicate that the Division anticipates a change in care may occur due to a medical condition after a medical event. The Division's Health Care Services Unit is responsible to assist with discharge planning for all consumers who are hospitalized. The discharge planning protocol for Health Care Services is to immediately begin, upon hospitalization, to plan for providing the service and supports necessary for the individual to return home after discharge, including the training of caregivers as appropriate. Qualified Vendors who anticipate a change in care, may initiate contact with Health Care services to participate in the discharge planning process.

The rate basis is an hour of direct care. The hours of authorized direct care for the home are shared among all consumers and converted to a daily rate as set forth in the RateBook.

AHCCCS encounter rules will not allow for the billing of one consumer to be in "two places one the same day." This is not dissimilar to billing for hospital days on the day of admission and the day of discharge.

The existing requirement to for the development of staffing hours in each home is determined by the District Resource staff working in cooperation with the Qualified Vendor. The Support Coordinator and ISP team are not responsible for this process.

---

**Section 7 Service Specifications**
**Habilitation, Individually Designed Living Arrangement**

**Comment:**
*There is no language concerning the ability to bill when the provider performs actions "on behalf of" the client. Will this be allowed?*

**Division Response:**
The ISP team is responsible for clarifying the activities and responsibilities of the consumer and other members of the team.

---

**Comment:**
*HAI - Service Objectives, 2.6 - Providing general oversight or supervision as identified in the ISP and the template for planning support (See Program Outcome Requirements, 1.) What is the Program Outcome Requirements?*

**Division Response:**
The reference to Program Outcome Requirements was included by error. The language has been revised.

---

**Comment:**
*"The Qualified Vendor must maintain on file proof of hours worked by their direct service staff…Each time sheet or equivalent document must be signed by the consumer/family/consumer's representative as verifications of hours served." Please clarify – this requirement is new?*

**Division Response:**
This is not a new requirement. When appropriate, the consumer should be the person signing the provider's time sheet to verify the service delivery.

---

**Section 7 Service Specifications**
**Habilitation, Habilitation Music**

**Comment:**
*Several Music Therapist expressed concerns related to the rate reductions that were implemented February 1, 2010.*

**Division Response:**
Habilitation Music is a method to deliver Habilitation, which is a way to help a person learn. While Habilitation is a service covered by the Arizona Long Term Care System (ALTCS), Habilitation Music is not specifically required. This means that individuals authorized to receive Habilitation Music will continue to have hourly Habilitation services authorized, but the provider will be reimbursed at the standard habilitation rate.

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**Comment:**
*We are asking that the Bachelor of Music please be added to the list to support the degree program offered in the state of Arizona.*

**Division Response:**
The Bachelor of Music has been added to support the degree program offered in the state of Arizona.

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**Comment:**
*The ten days requirement is sufficient for standard habilitation that may see the consumer for several days and several hours each of those days. However this time constraint is not reasonable for a therapy service that will see the consumer for 1 hour possibly 2 hours in that 10 day period. We ask that you consider restating this requirement to read "develop strategies for functional outcomes within 30 days after initiating service…".*

**Division Response:**
The Division has changed the requirement to reflect 30 days instead of 10 days.

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**Comment:**
*"The Qualified Vendor shall submit monthly progress reports…". In recognizing that this language was taken from standard habilitation where the consumer is seen multiple times a week for several hours at a time this requirement appears reasonable. However, in music therapy the consumer is typically seen 1x a week for a 1 hour session. In this situation quarterly reports seem more functional as they will give a better indication of the consumer's overall progress. Data is very easily skewed by one missed session or one "off" day when the data is only calculated from 4-5 total sessions as opposed to 12-14 total sessions.*

**Division Response:**
The requirement has been changed to quarterly reports.

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**Comment:**
*What about the training requirements?*

**Division Response:**
Training requirements are set forth in Arizona Administrative Code Article 15. These requirements include CPR, First Aid, etc.

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**Section 7 Service Specifications**
**Habilitation, Support**

**Comment:**
*In Service Requirements and Limitations (page 1), No. 7, can you please define "medically necessary", including what criteria are used, and who determines this?*

**Division Response:**
AHCCCS defines "medically necessary": As defined in 9 A.A.C 22, Article 1. Medically necessary means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life. Ultimately, the Division is responsible to determine that a service is medically necessary under the guidelines outlined by AHCCCS.

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**Comment:**
*In Service Requirements and Limitations (page 1), No. 8, to what natural supports is this referring? Does this include the parents? How do you determine how much support they are required to provide? A definition of natural supports, from DDD's perspective is needed.*

**Division Response:**
Natural supports vary based on the age of the consumer. A parent of a minor child has certain responsibilities as a parent to provide for the individual. Parents/guardians of adult consumers have a significantly different responsibility. The ISP assessment process reviews each individual situation and determines what is being provided by the family and others in the consumer's life. Areas that are not able to be met may then be appropriate for paid supports to be authorized.

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**Comment:**
*In Program Deliverables (page 4), No. 1.b., more definition is needed for "fading".*

**Division Response:**
As a consumer starts a new program, greater assistance from the trainer is typically required, with an eventual process of less (fading) assistance from the trainer as the consumer learns how to do the activity/function. While this has been removed from the RFQVA, this is considered best practice in habilitation.

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**Comment:**
*In Program Deliverables (page 4), No. 2, there is a requirement for an observation for each new direct care staff. This is an increase in monitoring that is not included in the rate.*

*No further details are provided for this observation – how long should it be, what criteria is being examined, what is to be reported, etc. What happens if the worker is transferring from another service, but has never had a review?*

*The Deliverables also state: Implementing all therapeutic recommendations including speech, occupation and physical therapy. Question: Are we able to work on the goals set fourth by the Therapy provider? Or do these goals need to still be different than the therapy goal?*

*Could you provide a clear description of what "direct supervision" means.*

*HAB, Support – 90-day visit – how long does the visit have to be, what are we observing, will there be reporting requirements? If they aren't providing HAH within 90 days, then is no observation is required? What if they provide HAH after their 90- days, then no observation*?

**Division Response:**
The RFQVA has been amended to remove the direct supervision of all new employees; however, providers need to employee good business practices regarding supervision and oversight of newly hired employees.

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**Comment:**
*In Recordkeeping and Reporting Requirements (page 5), No. 1, a more realistic timeframe for reporting would be 30 days.*

**Division Response:**
The Division has revised this reporting requirement from 10 days to 30 days. This request to change reporting requirements and the Division's response is common to a number of service specifications.

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**Section 7 Service Specifications**
**Individual Supported Employment**

**Comment:**
*The 75% requirement for consumers referred for job search to become employed is unreasonable, especially in the current economy*.

**Division Response:**
This is a service outcome for individuals referred for job search due to their enthusiasm for work, along with the team's interest and encouragement for community individual employment. The Division will be gathering data to assess whether this requirement should be revised and looks forward to working with the provider community in increasing employment outcomes.

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**Section 7 Service Specifications**
**Occupational Therapy**

**Comment:**

1. *There are multiple comments in regards to occupational therapy. In the Birth - 3 Therapy portion of the QVA, we had studied the consultative early intervention requirements. These requirements seem different from the past consultative model. For example: The vendor would be responsible to provide the service to their entire area and on the team there were early intervention specialists who could be doing the therapy if the team decided that that would be most appropriate. Is it indeed different, if not, where might I find the requirements of that model?*
2. *The commenter asked that the RFQVA add "sensory processing/sensory integration" needs, as a key area for evaluation by a qualified and trained occupational therapist. This term encompasses sensory perception, and how each sensory system correlates to the other, and when taken together into consideration, how these sensory systems help the child produce a purposeful and adaptive response to his/her environment. The commenter asked that the RVQVA add "play" skills, as this is the primary occupation of the child. Play is the foundation of development and learning, and it changes the brain (neuroplasticity).*
3. *"Functional living skills" should be re-worded as "activities of daily living skills", in order to encompass self-care, functional mobility/transfers skills, community integration/reintegration, leisure."*
4. *Change 6.4 to a broader term, neurodevelopmental functions—to encompass muscle tone, postural control, reflex integration.*
5. *For your consideration, it would also be crucial to include social-emotional developmental needs as a crucial area which impacts the child's overall*

*development and future engagement and participation in the society he or she is in.*

6. *"Equipment needs" should be re-worded as "adaptation and/or modification needs", to encompass a more universal term that includes the following: adapted devices and/or equipment for self-care, upper extremity orthotic devices, home/environmental modification, adapted equipment for mobility safety such as bath or feeding chairs…*
7. *Service Utilization Information No. 6 Recommended rewording, as follows--- The therapist participates in the needs assessment regarding adaptations or modifications (where "needs and modifications" have been previously defined as one of the domains of concern by the occupational therapist), by submitting appropriate documentation to support the recommendations, to the primary care provider, in order that the PCP may have substantial information to determine the medical necessity of such equipment needs.*

8. *It is felt that most if not all equipment are from third-party entities—e.g. manufacturers and/or distributors of the equipment. As such, the initial task and responsibility of training the family, therapist, other caregivers involved in the child's care, regarding said equipment, rests on the originating equipment provider. The equipment is under warranty, and thus, must be maintained by the equipment provider, for any on-going repairs needed and such. The therapist should NOT have that responsibility. The therapist may assist in communicating any concerns, needs for repairs or upkeep, to the equipment provider.*

*Rate Basis Comment: The Qualified Vendor retains the right to opt out of the contract, should the changes to the published rates cause an additional and unrecoverable financial and/or administrative burden to the Qualified Vendor, or if the published rates, upon research, are found to be incompatible with current market trends.*

**Division Response**

The Division is appreciative of the comments received from the therapy community. Each was reviewed carefully and whenever recommendations could be reasonably adopted, changes were made to the RFQVA.

Much of the substance in Comments 2, 5, 6, 7 and 8 was adopted into the RFQVA final service specifications.

In response to Comment 1, this provision is a guideline to assist with the compliance of AzEIP federal guidelines on timeliness. The Division has received comments that appear to be in response to the full early intervention, Team Based Model which is targeted to post in October for 30 days' public comment for implementation in early 2011. This will be a separate RFQVA that is not related to the current RFQVA that therapists are applying for beginning October 4, 2010 for contracts expiring December 21, 2010. Information on the upcoming Team Based model can be found on the AzEIP website.

In response to comment 9, under a published rate system, the Qualified Vendor is able to choose whether or not to offer services at the published rate.

The Division is not adopting the recommendations made in Comments 3 and 4 at this time.

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**Section 7 Service Specifications**
**Physical Therapy**

**Comment:**

1. *The Birth - 3 Physical Therapy portion of the QVA and in the past we studied the consultative early intervention requirements. These requirements seem different from the past consultative model. For example: The vendor would be responsible to provide the service to their entire area and on the team there were early intervention specialist who could be doing the therapy if the team decided that that would be most appropriate. Is it indeed different, if not where might I find the requirements of that model?*

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2. *Birth – 3 Physical Therapy - The Service Description first paragraph defines of physical therapy services as: A service that provides treatment to restore, maintain or improve function.*

   *The second paragraph of the Service Description states that physical therapy provides a consultation/ coaching model.*

   *This statement is inconsistent with the definition and core of concept what physical therapy is. It is crucial that a therapist not only evaluate, but provide treatment to understand the physical needs of their client, as well as their strengths. At that point teaching, training, consultation, coaching can occur to work towards and support the established functional outcomes.*

   *Please consider including an additional phrase, such as participation which is used for birth to three populations, as part of the description of what model physical therapy services includes.*

3. *Insurance Requirements for Therapies - As a physical therapist that has a very small contract, seeing fewer than 10 clients per week. I appreciate the requirement of professional liability insurance and understand the state's requirement to be included as an additional insured.*

   *However, I have never transported clients or families. I rarely drive to more than one client per travel. To have a state requirement that I include the state on my automobile insurance policy is an undue burden. Other agencies that actually provide transportation are not required to carry this type of insurance.*

*Please consider removing this excessive requirement from the new DDD contract.*

4. *Reporting Requirements - The amount of paperwork expected from the therapist is out of line. I suggest the following changes:*

   *Over 3 - annual progress report; progress is slow and goals are long term.*
   *Under 3 - bi annual progress report*
   *Those children who are not paid through DDD (have o visits authorized but remain DDD) should have an annual progress report.*

**Division Response:**

The Division is appreciative of the comments received from the therapy community. Each was reviewed carefully and whenever recommendations could be reasonably adopted, changes were made to the RFQVA.

In response to Comment 1, this provision is a guideline to assist with the compliance of AzEIP federal guidelines on timeliness. The Division has received comments that appear to be in response to the full early intervention, Team Based Model which is targeted to post in October for 30 days public comment for implementation in early 2011. This will be a separate RFQVA that is not related to the current RFQVA that therapists are applying for beginning October 4, 2010 for contracts expiring December 21, 2010. Information on the upcoming Team Based model can be found on the AzEIP website.

In response to comment 2: The Division pays for rehabilitative therapies through the subcontracted health plans for ALTCS members and these services would cover the direct therapies referenced in the comment. The habilitative therapies provided through the Division directly are to be provided as consultative, ensuring the consumer and direct caregiver(s) are involved to provide more functional opportunities for improvement.

In response to comment 3: The insurance requirements are established by the Arizona Department of Administration for all state contracts and the Division is not able to modify these requirements.

In response to comment 4: The reporting requirements are consistent with the expectation that progress is shown or objectives are adjusted as needed. Annual or biannual reports would not provide the ISP with sufficient information to determine the efficacy of the therapy provided.

**Section 7 Service Specifications**
**Respite**

**Comment:**
*Under Service Requirements and Limitations (page 1), No. 1, community sites not inspected by DES are not listed as an acceptable site for service delivery. Does this mean parks, malls, community dances, movie theaters, etc. are not acceptable sites?*

**Division Response:**
A provider residential setting that is not inspected and identified as acceptable can not provide respite in the setting. This does not apply to community outings.

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**Comment:**
*There is no clarification as to hourly versus daily respite. What will the definitions be and how will they be reimbursed?*

**Division Response:**
The reimbursement methodology and definitions for respite will be further clarified during November.

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**Comment:**
*The Service Utilization Information section (page 2), No. 4, indicates that providers should receive reimbursement for non-client children who are being watched with a client from the parents. Parents who are billed rarely pay. How is DDD going to verify how many people have been served?*

**Division Response:**
The Division could verify in a number of different methods including but not limited to self reporting by the family, direct care staff, etc.

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**Comment:**
*Under Direct Service Staff Qualifications (page 3), No. 1, there is a requirement for 3 months experience. Why is this necessary with the new training and monitoring requirements and background checks?*

**Division Response:**
The 3 months of experience is required by A.A.C. R6-6-1529 and R6-6-1532.

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**Section 7 Service Specifications**
**Room and Board, All Group Homes**

**Comment:**
*In the Service Goals and Objectives Section (page 2), No. 3, the revised service specifications indicate that providers shall submit their weekly menus at the end of the month to the DPM or designee. Many providers currently do not have menu planning, nor do they post menus. In conjunction with clients, they develop the grocery list, shop and cook. Why does DDD want to require the weekly menus, and will the menu planning requirement now be enforced?*

**Division Response:**
The Division has changed this requirement and menus are only required to be submitted to the District upon request. The most important component of menu planning, besides ensuring appropriate and nutritious meals, is involving consumers in menu planning.

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**Comment:**
*In the Recordkeeping and Reporting Requirements Section (page 3), No. 2 requires that the Qualified Vendor maintain weekly menus. For how long?*

**Division Response:**
State law requires that records be retained by Qualified Vendors. Records that demonstrate that the Qualified Vendor has met a contractual requirement must be kept during the term of the contract and for 5 years after the contract ends, 6 years after the contact ends for HIPAA records.

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**Section 7 Service Specifications**
**Speech Therapy**

**Comment:**
*The Birth - 3 Speech Therapy portion of the QVA and in the past we studied the consultative early intervention requirements. These requirements seem different from the past consultative model. For example: The vendor would be responsible to provide the service to their entire area and on the team there were early intervention specialist who could be doing the therapy if the team decided that that would be most appropriate. Is it indeed different, if not where might I find the requirements of that model?*

**Division Response:**
The Division is appreciative of the comments received from the therapy community. Each was reviewed carefully and whenever recommendations could be reasonably adopted, changes were made to the RFQVA.

In response to comment 1 regarding the consultative model for birth to 3, this provision is a guideline to assist with the compliance of AzEIP federal guidelines on timeliness. The

Division has received comments that appear to be in response to the full early intervention, Team Based Model which is targeted to post in October for 30 days public comment for implementation in early 2011. This will be a separate RFQVA that is not related to the current RFQVA that therapists are applying for beginning October 4, 2010 for contracts expiring December 21, 2010. Information on the upcoming Team Based model can be found on the AzEIP website.

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**Comment:**
*Will a current QVA provider have to resubmit the entire QVA application or will there be a "fast track" for vendors already in your system?*

**Division Response:**

New Applicants:
All parts of the application must be completed. Please refer to the QVADS User Manual for New Applicants that is posted at: http://www.azdes.gov/ddd.

Current Qualified Vendors:
In order to reduce the administrative burden for current Qualified Vendors, the application process has been modified. For instructions, current Qualified Vendors should refer to the QVADS User Manual for Existing Qualified Vendors that is posted at: http://www.azdes.gov/ddd/. Specifically, current contract information as of September 30, 2010 will be available, can be viewed, saved if changes are required and then submitted. To the extent that current Qualified Vendors have maintained information contained in the general information section and service questions of the Qualified Vendor system, this information can be simply resubmitted. If the current Qualified Vendor desires to make changes, then changes can be completed, saved and then submitted. New hardcopy documents and information will need to be submitted such as Assurances.

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**Comment:**
*Speech Therapy- 3+Service Requirements and Limitations, No 7 states that the care plan must be reviewed at least every 62 days, it states this after it states that services require PCP or Physician's orders and must be included.*

*Who is required to review this is it the PCP, the team, the support coordinator or the Therapy Provider? If it is one of the latter does that then require quarterly notes be done not quarterly but, every 62 days? And why 62 Section 2.2.1 states: The ISP team will identify functional outcomes to be incorporated into the consumer's daily activities.*

**Division Response:**
The prescription needs to be within one year to be valid. Quarterly reports are due 15 days after the quarter ends. The primary care provider/physician and the team should be given the care plan for review.

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**Comment:**
*Does this mean that the team will write the Therapy goals during ISP's and submit them or is the Therapist still able to discuss this with the parent/responsible person during visits and come up with the goals during this time?*

**Division Response:**
The ISP team has always identified the functional outcomes as part of the ISP progress. The therapist should discuss this with the parent/responsible person. Typically, therapists write very specific goals to meet the functional outcomes already identified. If an alternative functional outcome is needed, a Change in the ISP can be completed.

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**Comment:**
*Third Party Liability (TPL) - In order to receive payment from insurance carriers or 3rd party payors speech therapy services will be paid only if "medically necessary" secondary to accident, injury, or congenital condition. The insurance carriers are now enforcing this policy strictly. Everyone wants someone else to pay! This means all prescriptions from PCP's must state a medical diagnosis. (No speech and language delay! That's an automatic denial of coverage.) Every report has to have a medical code and is immediately denied if it is related to a "delay".*

*When doing progress reports and indicating diagnosis if it is not medically related they will not pay which means DDD will have to pick up the entire bill. I am now busy submitting documentation to almost all the insurance carriers and ultimately talking with the medical director. If our progress reports mention "consultation" or "education" or "training" that is not helpful. In addition, we have to make a medical case for payment to occur. I work hard to get insurance to coverage therapy but I must keep my progress reports more clinical or medical based and substantial. I can't put in a goal like "child will say "mom and dad", even if that's what the parent wants. I try to focus on the medical aspects that are interfering with the child's ability to form speech sounds or achieve intelligible speech. I try to focus on the issues of aspiration of liquids due to poor oral pharyngeal control and how I plan to improve those skills. I try to focus on how I plan to teach the child the skills necessary to chew, bite and direct food safely for chewing.*

*My point is that the insurance companies are clear that they are only paying for children that have a medical issue. I have always tried to get insurance to pay even going back and disputing before submitting to DDD. I feel if we are all doing that then we could and would be saving DDD money. I thought that is what we are supposed to do. If we are writing documents focused on natural environments and family focused goals with consultation and training insurance will automatically kick that out. Remember, insurance carriers are more trained for medical documents coming from hospital and rehabilitation centers. Then we submit "educationally based documents" and that's a no go!*

*I am just wondering if that has been taken into consideration in our current approach. Insurance is a real frustration at this time. I can't write a separate document for every DDD child I see specifically for insurance. My progress report for DDD does double duty. Please comment.*

**Division Response**
Medicaid and AHCCCS set the third party liability requirements that require a service provider to obtain payment from any available third party payer before billing the state for the service. As a result, therapists must bill insurance companies and any other available third party payer and provide the Division with proof of payment or denial from the third party payer in order to be paid by the Division. The Division understands Third Party Liability is complex and we offer training and technical assistance on third party liability. The schedule of upcoming training is available at https://www.azdes.gov/main.aspx?menu=96&id=2668

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**Section 7 Service Specifications**
**Transportation**

**Comment:**
*Providers would like more information about the Service Description (page1), which states that the service "provides or assists in obtaining various types of transportation for specific needs", specifically, clarification as to the "assists in obtaining".*

*What does this entail? If a consumer's family moves outside of the catchment area for a DTA program, but the family still wants to consumer to attend that program, does the DTA provider have to assist in obtaining transportation?*

**Division Response:**
The responsibility of the DTA provider to assist in obtaining transportation is a subject for the ISP team. A consumer's specific needs are a factor for the provider to consider when responding to a vendor call or referral for services.

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**Comment:**
*Under Service Objectives (page 2), No. 3, there is a requirement that transportation be arranged so the consumer does not have to wait more than 20 minutes. Does this also apply to group home providers?*

**Division Response:**
This service specification is not applicable to group homes.

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**Comment:**
*In Service Requirements and Limitations (page 1), No. 1b, who will decide if the service is an extraordinary burden on the developmental or group home provider?*

**Division Response:**
The Division makes a determination on extraordinary circumstances based on information provided by the provider and other available information.

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**Comment:**
*Under Service Utilization Information (page 3), No. 3, there is a statement that an aide may be required to accompany a consumer to ensure his/her health and safety. If the ISP Team decides this, will DDD reimburse for a 1:1 aide?*

**Division Response:**
Based on the consumer's individualized support plan (ISP) and ISP team recommendation, a special rate may be available if prior authorized by the Division's central office.

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**Comment:**
*Under Service Utilization Information (page 3), No. 4, providers would like clarification of when this would be appropriate.*

**Division Response:**
The option to wait for a consumer to provide round trip transportation only applies to on-demand transportation. Dependent on each individual circumstance, it maybe appropriate in some instances, such as for some medical appointments.

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**Comment:**
*In the Recordkeeping and Reporting Requirements (page 4), the agreement states that "the records shall include, at a minimum by consumer, the consumer's name and identification number, date of service, mileage, and pick up and drop off times. The records must be signed by the consumer, family or consumer's representative as verification of services provided." Since 2003, the provider association has had several discussions with DDD about removing this requirement. The level of documentation associated with these requirements is significant and does not add value. The provider, who is transporting numerous clients to a variety of locations, has to stop and record the time and mileage while obtaining a signature at each stop. Also, to what services does this apply?*

**Division Response:**
This service specification has been revised in response to this comment. The RFQVA was changed to clarify separate requirements and instructions for on demand and scheduled transportation. Scheduled transportation will require the consumer's name,

date of service, time picked up and dropped off. While the mileage and signature requirements have been removed from the RFQVA, the Qualified Vendor remains responsible and should be able show verification have for following each consumer's ISP regarding if the consumer can be alone when returned home or if someone is to be present at the home, following transportation.

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**Section 9H Business Plan Outline**

**Comment:**
*Our providers, who are well-established, long-term state contractors, are offended by this requirement, and would like to understand why the State is requiring additional unfunded mandates when we are already operating under severe funding cut-backs.*

**Division Response:**
This business plan outline is not required for existing Qualified Vendors. However, an annual financial statement is required. New applicants that are not previous DES/DDD Qualified Vendors will be asked to submit a business plan.